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ABSTRACT

These hearings transcripts present testimony before the Senate Committee on Labor and Human Resources to address the question of how to improve the health care status of American children. The hearings addressed a range of issues relating to children's health from witnesses with expertise in pediatric care, public health, mental health, and substance abuse. Each witness addressed the following four questions: (1) "What are the health-related needs of children that we should work to fulfill?"; (2) "How can we better address children's health needs through improvements to federally-funded public health programs?"; (3) "How do you propose we address the problem of ensuring health coverage to children who are currently uninsured, and what should be the Federal role in that endeavor?"; and (4) "How might we encourage the private sector to participate in partnerships with our Government and community organizations to address the needs of children?" Specific child health issues addressed by a variety of witnesses included pediatric illness, children not covered by health insurance, quality care, substance abuse, care delivery systems, child and adolescent psychiatric services, oral health, and prenatal care. Speakers included Senators Orrin G. Hatch (Utah), Edward M. Kennedy (Massachusetts) and Barbara A. Mikulski (Maryland); Secretary of Health and Human Services Donna Shalala; hospital administrators and other administrators of organizations concerned with child health. (Author/SD)

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IMPROVING THE HEALTH STATUS OF CHILDREN

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HEARING

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

ON

EXAMINING PROPOSALS TO IMPROVE THE HEALTH STATUS OF CHILDREN, INCLUDING S. 435 AND S. 525, FOCUSING ON PEDIATRIC CARE, PUBLIC HEALTH, MENTAL HEALTH, AND SUBSTANCE ABUSE ISSUES

APRIL 18, 1997

Printed for the use of the Committee on Labor and Human Resources

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IMPROVING THE HEALTH STATUS OF CHILDREN

FRIDAY, APRIL 18, 1997

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 9:33 a.m., in room SD–430, Dirksen Senate Office Building, Senator Jeffords (chairman of the committee) presiding.

Present: Senators Jeffords, Collins, Kennedy, Dodd, Harkin, Mikulski, Wellstone, and Reed.

OPENING STATEMENT OF SENATOR JEFFORDS

The CHAIRMAN. The Committee on Labor and Human Resources will come to order.

We have an excellent hearing for you this morning, and we want to get started right away. Senator Kennedy and I both will give our opening statements.

Today, we will address the question of how to improve the health care status of our children. It is absolutely critical that we commit ourselves to giving our children the best possible start in life, thus ensuring a solid foundation for our country's future. Without good health, a child cannot learn and cannot thrive, and his or her opportunity to contribute to a strong society is compromised.

This hearing will address a range of issues relating to children's health. We will hear from witnesses with expertise in pediatric care, public health, mental health, and substance abuse. Speaking from his or her own particular area of expertise, each of the witnesses will address the following four questions: 1) What are the health-related needs of children that we should work to fulfill?

2) How can we better address children's health needs through improvements to federally-funded public health programs?

3) How do you propose we address the problem of ensuring health coverage to children who are currently uninsured, and what should be the Federal role in that endeavor?; and 4) How might we encourage the private sector to participate in partnerships with our Government and community organizations to address the needs of children?

We will also hear from Senator Hatch and Senator Specter, each of whom has introduced a bill designed to address concerns about health coverage for children. Secretary Shalala is here. I know that she, too, is committed to addressing concerns about children's health. And, finally, I want to welcome Governor Dean from Ver-

mont. He is a national leader in children's programs, and I am very pleased that he is here to share with the committee the successes of Vermont's programs.

I want to thank both Senators Hatch and Specter for being here. Because of our lengthy agenda, I am going to ask that you take 5 minutes each and then be open for questions. But, first, I am going to turn to Senator Kennedy.

[The prepared statement of Senator Jeffords follows:]

PREPARED STATEMENT OF SENATOR JEFFORDS

Today we will address the question of how to improve the health status of our children. It is absolutely critical that we commit ourselves to giving our children the best possible start in life, thus ensuring a solid foundation for our country's future. Without good health, a child cannot learn and cannot thrive, and his or her opportunity to contribute to a strong society is compromised.

This hearing will address a range of issues relating to children's health. We will hear from witnesses with expertise in pediatric care, public health, mental health, and substance abuse. Speaking from their own particular area of expertise, each of the witnesses has been asked to address the following four questions:

1) What are the health-related needs of children that we should work to fulfill?

2) How can we better address children's health needs through improvements to federally-funded public health programs?

3) How do you propose we address the problem of ensuring health coverage to children who are currently uninsured, and what should be the federal role in that endeavor?

4) How might we encourage the private sector to participate in partnerships with government and community organizations to address the needs of children?

We also will hear from Senator Hatch and Senator Specter, each of whom has introduced a bill designed to address concerns about health coverage for children. Secretary Shalala is here. I know that she, too, is committed to addressing concerns about children's health. Finally, I want to welcome Governor Dean from my home State of Vermont. Vermont is a national leader in children's programs, and I am very pleased that Governor Dean is here to share with the committee the successes of Vermont's programs.

Our goal is to ensure that children have a healthy start in life in preparation for a lifetime of learning. To achieve this goal, we should consider the many medical, social, and environmental factors that contribute to a child's health. A healthy, thriving child is, among other things, free of sickness or disease, has a full and well-balanced diet, breathes clean air, wears a seatbelt, and lives in a safe home.

This committee has jurisdiction over the vital public health programs that are largely responsible for the biggest health gains we have made in this century. Thanks to investments in research and immunizations we no longer fear that our children will contract diseases such as polio or smallpox. In the 1960s, a public health official recognized the correlation between leaded gasoline and blood lead levels in children. Because of her efforts and the support of the Federal Government, the incidence of lead poisoning has

been dramatically reduced. Through our public health programs we have reduced the transmission of the HIV virus from mothers to infants, and have drastically reduced the number of childhood injuries through the use of seatbelts and bicycle helmets. Many of our public health programs will be reauthorized in this Congress, and we would be remiss to have a hearing on children's health that does not recognize the great contributions that these programs have made to improving children's health.

In addition to the public health programs that are within the jurisdiction of this committee, we also will have the opportunity to improve children's access to good medical care and prevention by working to ensure that they have health coverage. Many in this Congress are committed to improving health coverage for children. With nearly ten million uninsured children in our country it is a problem that deserves our attention. Three million of these uninsured children are already eligible for Medicaid but do not participate. We need to find a way to reach out to these children, and work in partnership with the States to ensure good health care to the remaining seven million.

Several bills designed to address this problem have already been introduced, and others will be offered in the near future. Working with several other members, I too expect to introduce a bill soon. I look forward to working with all of my colleagues to move forward on a solution that will provide the coverage children need and that will pass both the House and the Senate.

There is no doubt that it is an ambitious undertaking to assure that each child is able to live in the healthy environment he or she deserves. But we can strive for nothing less. Our task is to ensure that our children are ready to go to school, ready to read, ready to learn, ready to interact with other children, ready to grow into contributing members of society.

I want to welcome all of you, and in particular say thank you to our witnesses for taking time to join us today. I look forward to hearing the testimony.

OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. Thank you very much, Mr. Chairman.

Welcome, Senator Hatch, Senator Specter.

I commend Senator Jeffords for calling this hearing on improving the health status of children. Senator Jeffords and this committee have long been committed to improving health care for children and of all Americans, and I look forward to working together on this very important issue.

Children are the Nation's future. Every child deserves a healthy start in life. Every hardworking family deserves the security of knowing that they will be able to afford health care for their children that their children need. Healthy children are children whose mothers receive timely prenatal care. Healthy children receive good postnatal care. Healthy children receive all the necessary immunizations and well child care. Healthy children receive all the necessary diagnosis, treatments and care for their injuries and illnesses. Healthy children live in houses free of abuse and neglect. Healthy children get nutritious meals, have good child care, live in

a community free from violence, free from guns, and free from drug and alcohol abuse, and healthy children do not smoke cigarettes.

To improve the health status of children, we must ensure that children have timely access to high-quality health care and a strong public health system to back it up.

Numerous public health problems need to be resolved if we are to succeed in meeting the needs of children. Programs on maternal and child health, immunization, substance abuse, mental health, health research, health professions child care and Head Start are all under the jurisdiction of this committee. So I look forward to working with the members to strengthen these programs and ensure that they are adequately funded.

There is a significant step that we can take to improve the lives of children right now, this year, by providing health insurance to the millions of children who have no insurance today. All families deserve the security of knowing that they will be able to afford the medical care their children need.

Last week, under the leadership of Senator Orrin Hatch of Utah, the Senator and myself introduced bipartisan legislation that could be a major step toward making health insurance accessible and affordable for all children. We call it the CHILD bill. I would mention that our chairman is a cosponsor of that bill, as well as Senator Wellstone and others. It is cosponsored by a majority of the members of this committee. I am especially pleased that Senator Hatch, who is a former chairman of this committee, is here to testify about our bill today.

Throughout his career in the Senate, Senator Hatch has been committed to improving the lives of all Americans, especially children. America owes Senator Hatch a vote of thanks for his dedication to children. No one is more effective at fighting for what is right for children and putting politics aside to help those most in need.

As Senator Hatch so often states, it is not a Republican issue or a Democrat issue, but a human issue. He is absolutely right. There is nothing more important to every family than their children.

I was pleased to note that Senator Gramm announced yesterday that the Senate Republican Task Force has a proposal to bring health insurance to more American children. Their specific proposal is, however, deeply flawed. It finances expanded coverage by cutting the Earned Income Tax Credit that goes to low-income workers, in effect robbing poor Peter to pay poor Paul. The funds are not adequate to serve more than a small fraction of uninsured children. The proposal even envisions a so-called medical savings account for low-income families, as if children and families with incomes of $15,000, $20,000, or even $30,000 a year would really benefit from policies that require a minimum deductible of $3,000 before insurance benefits even begin.

But the fact that this important group has recognized that health insurance for children should be a priority makes me even more optimistic about the chances for action this year, and I look forward to working with them.

Our goal is to make health insurance coverage available to all uninsured children under 19 years of age. The legislation Senator Hatch and I have introduced provides grants to the States to con-

tract with private insurers to provide coverage to uninsured children. Subsidies would be available to families who cannot afford to purchase this coverage on their own.

This program is financed by an increase of 43 cents a pack in the cigarette tax, which will raise $30 billion over the next 5 years. Two-thirds of the funds will be used for children's health insurance and one-third for deficit reduction.

It makes sense to finance coverage through an increase in the cigarette tax because smoking is the number one preventable killer of Americans of all ages, and it imposes costs on the country of an estimated $100 billion a year.

If we do nothing, 5 million of today's children will die from smoking-related illnesses. One of the most important steps we can take to save children from this deadly addiction is to raise the price of cigarettes by raising the cigarette tax.

We read in The Washington Post this morning that even a 50-cent-per-pack increase in the price of cigarettes would scarcely make a dent on the industry, as one of the industry spokesmen stated. I call on the tobacco industry to support our legislation. It is time they took at least this small step to make amends for the damage they have done to American children for so many years. And if there is a settlement of the State attorney general suit against the tobacco companies, there are basic conditions that should be included—the FDA's authority to regulate cigarettes should not be limited because this product is too harmful to tie the hands of the FDA, and I believe that enactment of legislation to provide health insurance to children financed by cigarette tax increases should be part of any legislated settlement endorsed by the Congress.

This is the year for action to guarantee every American child health insurance. Each day we delay means that more children fail to get the health care we need. When we fail our children, we also fail our country and its future.

I thank Senator Hatch very much for his leadership, and I want to note that Senator Specter has introduced legislation as well to address the needs of children, so we join in welcoming him.

The CHAIRMAN. Thank you.

Next, I will call on two Senators who have done so much in this area. Senator Specter, especially in the last session, as chairman of the subcommittee dealing with the allocation of our scarce resources in this area, did an incredible job last year by introducing a program of which we can all be proud.

Senator Hatch has already been mentioned in connection with the bill we are considering today. He made a tremendous contribution as a member of this committee for many years, and we miss him here—but, of course, I miss him less than some others, because he would be chairman. [Laughter.]

Senator Hatch, please go ahead. I am going to ask that you both be guided by the timer, because we do have a long series of witnesses this morning.

Senator Hatch.

STATEMENTS OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM THE STATE OF UTAH; AND HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA.

Senator HATCH. Thank you, Mr. Chairman. I may go just slightly over, but I will try to live within the constraints.

I am honored to be here with my good friend and colleague, Senator Specter, who I think has worked hard in this area and has a very interesting bill as well. I have great respect for him.

I have been to SD-430 twice this week, so it feels as though I have never left. As you know, I spent what I consider 18 very productive years here—or nonproductive, if you count the filibusters that I was compelled to lead against various pieces of legislation that we all remember, don't we, Ted?

Senator KENNEDY. That is right. [Laughter.]

Senator HATCH. Fortunately, that will not be the case with child health legislation. This committee ha a record of enacting a wide range of domestic policy legislation to help all Americans, particularly the most vulnerable of our society, and I was always proud to be a part of it. And I know that the Labor Committee under your leadership, Chairman Jeffords, is destined to do even more.

The fact that you are holding this hearing today underscores the committee's concern and commitment to alleviate the worst fear of parents—a sick child—and even worse, a sick child without health insurance.

Millions of parents all over this country have to deal with fear every day. It is now time for Congress to provide them with some relief. Since our time is short this morning, I will keep my remarks brief and submit my longer statement for the record.

As you know, I am the author along with Senator Kennedy of the Child Health Insurance and Lower Deficit Act, or CHILD bill, as we call it. They call us the "odd couple"; on the other hand, we have worked together on an awful lot of health legislation over the last 21 years, and I want to pay particular tribute to my friend and colleague for being willing to create a bipartisan bill that will hopefully get rid of the political problems that we have in our society and get us working together.

I am pleased to be joined in that effort by 19 of our colleagues, including from this committee, Senator Kennedy, Chairman Jeffords, and Senators Collins, Dodd, Bingaman, Wellstone, Murray, Reed and Mikulski. We fully expect to add additional Senators to the list in the weeks ahead, and I would like to make a pitch to all Senators on the Labor Committee to join us in cosponsoring this measure before it reaches the Senate floor.

Senator Specter, I know that you have your own bill, and I think it is very similar to ours, so I hope we are going to be able to sign you up right after this hearing, but if not, I have tremendous respect for the work that you have done in creating your bill, and I certainly respect you, as you know. We serve together on the Judiciary Committee.

After considerable study of child health, three facts have become abundantly clear to me. One, children are our future. Perhaps that is a cliche, but it is true. Child health and welfare should be the concern of every member of this body.

Second, the current system falls woefully short. Some studies say as many as one in three children do not have health insurance. And what is even more disturbing to me is the fact that 86 percent of these children are from families where one or more parent is working hard yet not earning enough to purchase health insurance.

I have been as frustrated as any American taxpayer that some people have taken unfair and unintended advantage of our public assistance programs as enthusiastically supported welfare reform. But I do believe in giving aid for effort, and that is our aim here.

And third, we cannot improve the current system without a bipartisan, bicameral approach that is targeted, fully financed and built on the current system.

I am pleased that Secretary Shalala will be here today because the support of the administration is critical to this endeavor. I think we all recognize that the administration has included a package of child health proposals in its budget.

Today I want to challenge Secretary Shalala to endorse the CHILD bill and to work actively for its passage. The administration's fiscal year98 budget said, "The President is pleased with the widespread congressional interest in expanding health care coverage for children, and he looks forward to working with both Democrats and Republicans to develop and implement proposals to reach that goal."

We now have a bipartisan, bicameral proposal, the Hatch/Kennedy/Johnson/Matsui bill, and it is time for the President to climb aboard. The sponsors of our legislation have worked hard to address the issues in a fiscally responsible way. Our bill is a limited authorization of 5 years which is fully financed and which allows States considerable latitude in establishing their own programs. State participation is voluntary.

The bill is financed by a 43-cent user fee or increase in the cigarette excise tax, with proportionate increases in other tobacco products. I think that that is entirely justified, given the enormous public health threat associated with tobacco use.

One-third of the revenues the bill raises will be used to reduce the deficit, one of the biggest burdens there is on children.

I know that not all of my colleagues are comfortable with the funding source or indeed with all of the provisions of the bill. I ask them to keep an open mind, as will I. I want to work with each of our colleagues to address your concerns if we can.

What we have to keep in mind, though, is the children. There is ample evidence for action. Recent studies have shown that about 10 million children are uninsured and, as the GAO reported last week at a House hearing, "Without health insurance, many families face difficulties getting preventive and basic health care for their children." GAO noted that, "Children without health insurance are less likely to have routine medical and dental care, establish a relationship with a primary care physician, and receive immunizations or treatment for injuries and chronic illnesses."

The plain truth is that we need to get our kids off to a healthy start, and in the end, we will reap dividends thereafter, because if we do not, we will pay more as a society and as a government in the long run.

I am very grateful that my family has been blessed with good health. I am also grateful that the members of my family have health insurance. But millions of Americans do not rest easy with that peace of mind because they do not.

I come before you today in two capacities—both as the father of six and as the grandfather of 17, but also as a Senator who recognizes that there are times when we have got to set politics aside for the good of the Nation. We have the opportunity now to forge an essential bipartisan alliance to get the job done in a way that does not create huge bureaucracies, new entitlements or run up even greater deficits. And I hope that history will record that we did the right thing. Our children and their children are counting on us.

Mr. Chairman, may I take just a couple of seconds more to show these charts that we have?

The CHAIRMAN. Yes, please do.

Senator HATCH. I will just run through them very quickly, if I can.

In this country, one-third of our kids are not insured. That is abominable. It is outrageous. Yet we have people who are fighting almost anything that comes up in this area. The CHILD Act that we are talking about will provide $20 billion in health insurance and direct services over the next 5 years, and it has a deficit reduction component of $10 billion, for a total of $30 billion over 5 years.

The CHILD Act is voluntary, it is fiscally responsible, it is fully funded. It is not an entitlement in spite of some of the misrepresentations. It has a private sector role, and it has minimum bureaucracy because the Internal Revenue Service already collects the cigarette excise tax, and it is no big deal for them to do it in the future with this expanded role. And I might add that HHS distributes the funds in accordance with the Medicaid formula, and that is no big deal and should not create any more bureaucracy. This bill helps kids.

It is not an entitlement. It is a 5-year authorization appropriated from tax revenues. The size of the program is capped, and there are no individual rights to benefits. They are only there as long as we have the funds that come in and over this period of time. If it does work and work well over the 5-year period, then I hope it will be reauthorized, naturally.

There is no Government takeover. It is a program of private insurance. It is run by the States. It is totally voluntary. There is a minimal Federal role to collect and disburse funds and a simple allocation formula.

With regard to smoking, people have got to know this. Smoking causes cancer and is addictive. As Senator Kennedy says, it is the largest preventable cause of death in the United States today. Forty-eight million Americans smoke, but we have got to add to that 3 million teenagers. Fifty-one million Americans are already smoking. Four hundred and nineteen thousand American smokers die annually from smoking-related diseases. One out of five U.S. deaths is smoking-related. Four out of five smokers begin by the age of 18, half by the age of 14. Each day, 3,000 kids begin smoking, and half of them will become addicted to nicotine.

Last but not least, the societal cost of smoking, many estimate to be as high as $100 billion annually—$50 billion in direct medical costs. We are asking for $3 billion for the first 2 years, $4 billion for the third, and $5 billion for the last 2 years.

Of 24 billion packs of cigarettes sold in 1993, the average was $2.06 per pack in medical care costs, and of this, 89 cents was paid by public sources. So, we are looking at $10 billion in Medicare, $5 billion in Medicaid, $4.75 billion in other Federal expenditures, and $16.75 billion in higher insurance premiums. It is a big problem in our society, and I have got to say that the excise tax has not been kept commensurate with the increase in the profits and costs of cigarettes in our society.

Mr. Chairman, I did go slightly over, and I apologize, but this is important, and I just hope we can get people to get behind this bill and get it done this year.

Thank you.

The CHAIRMAN. Thank you very much, Senator.

[The prepared statement of Senator Hatch follows:]

PREPARED STATEMENT OF SENATOR HATCH

Mr. Chairman, thank you for your invitation to testify on this important legislation. I've been to SD–430 twice this week. It is beginning to feel like I never left. I spent 18 very productive years—or nonproductive if you count the filibusters I was compelled to lead against the various hair-brained proposals Senator Kennedy was then promoting—as a member of this committee.

We did a lot of historic work on a wide range of domestic policy issues that affect all Americans, particularly the most vulnerable in our society. I was proud to be a part of it. And, I know the Labor Committee under the leadership of Senator Jeffords is destined to do a lot more.

The fact that you are holding this hearing today Mr. Chairman underscores the committee's concern and commitment to alleviate the worst fear of a parent—a sick child. And even worse, a sick child without insurance.

Millions of parents all over this country have to deal with this fear every day, and I believe that it is now time for Congress to provide them with some relief.

I know that our time is short this morning and so I will keep my remarks brief and submit my longer statement for the record.

As members are aware, I am the author of the Child Health Insurance and Lower Deficit Act, or the CHILD bill, as we call it. I am pleased to be joined in that effort by 19 of our colleagues, including from this Committee Senator Kennedy, Chairman Jeffords, and Senators Collins, Dodd, Bingaman, Wellstone, Murray, Reed, and Mikulski.

We fully expect to add additional Senators to the list in the weeks ahead.

I would like to make a pitch to all Senators on the Labor Committee to join us in cosponsoring this measure before it reaches the Senate floor.

Senator Specter, I know you have a bill, but I hope we are going to be able to sign you up right after this hearing.

After considerable study of child health, three facts have become abundantly clear to me:

1) First, though it may be a cliche, it is no less true that children are future. Their health and welfare should be a concern of every member of this body.

2) Second, the current system falls woefully short. As many as one in three children do not have health insurance. And, what is even more disturbing to me is the fact that so many of these children are from families where one or both parents is working hard, yet not earning enough to afford insurance. I have been as frustrated as any American taxpayer that some people have taken advantage of our public assistance programs as enthusiastically supported welfare reform. But, I do believe in giving aid for effort.

3) And, third, we cannot improve the current system without a bipartisan, bicameral approach that is targeted, fully-financed, and built on the current system.

I am pleased that Secretary Shalala is here today, because the support of the Administration is critical to this endeavor. I think we all recognize that the Administration has included a package of child health proposals in its budget.

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Today, I want to challenge Secretary Shalala to endorse the CHILD bill and to work actively for its passage.

The Administration's FY 1998 budget said, "The President is pleased with the widespread congressional interest in expanding health care coverage for children, and he looks forward to working with both Democrats and Republicans to develop and implement proposals to reach that goal."

We now have a bipartisan, bicameral proposal, the Hatch/Kennedy/Johnson/Matsui bill, and it is time for the President to climb aboard.

As the committee may be aware, the General Accounting Office reported last week at a House hearing that, "Without health insurance, many families face difficulties getting preventive and basic health care for their children."

The GAO report continued that "Children without health insurance are less likely to have routine medical and dental care, establish a relationship with a primary care physician, and receive immunizations or treatment for injuries and chronic illnesses."

The plain fact is that we need to get kids off to a good start. Because if we don't, we will pay more as a society and as a government in the long term.

There was a commercial by an automotive repair company several years ago about the importance of preventive and periodic care. In this case, it had to deal with changing the oil in your car on a regular basis. The commercial slogan was, "You can pay me now, OR, you can pay me later."

The inference is clear.

We want our kids in good health from their beginning. We want our kids to get early and routine preventive and basic health care. And, we want our kids to receive early diagnostic care before serious illnesses arise.

Mr. Chairman and members of the committee, I come before you today in two capacities—both as a father of six and a grandfather of 17, but also as a Senator who recognizes that there are times when we have to set politics aside for the good of the nation. We have the opportunity now to forge an essential bipartisan alliance to get the job done in a way that does not create huge new bureaucracies, new entitlements, or that runs up the deficit. I hope history will not write that we blew it.

I am very grateful that my family has been blessed with good health. I am also grateful that members of my family have health insurance. But millions of Americans do not rest easy with that peace of mind.

These are the parents of an estimated 10 million children who are chronically uninsured.

In other words, they are without health insurance for at least one year.

Again, citing the GAO testimony, "Between 1989 and 1995, the number of children increased by almost seven million, but the number of children with private health insurance coverage remained virtually unchanged. And despite efforts expanding Medicaid eligibility to an additional six million children, the number of uninsured children grew by more than one million—reaching almost 10 million uninsured children in 1995 . . .

More than 500,000 infants are born into this country every year without insurance.

These statistics are simply unacceptable.

The consequences are serious.

According a recent survey by the Kaiser Family Foundation, "45 percent of uninsured adults had problems getting health care and most reported having serious financial and health consequences as a result." In addition, "people without health insurance tend to forego health care more than those with health insurance, and therefore, when the uninsured seek care, their condition often is more advanced and thus, more expensive to treat."

And, as we know, people without insurance tend to seek care at hospital emergency rooms thereby increasing the financial burden on these institutions.

Senator Kennedy and I have spent a considerable amount of time over the past several months exploring ways we both could agree on in addressing this problem.

At times our sessions were acrimonious (is that a fair assessment, Ted?), at times arcane, but always well-meaning.

On April 8, 1997, Senator Kennedy and I introduced S. 525, the Child Health Insurance and Lower Deficit Act, or CHILD legislation.

Let me briefly summarize the major components of the CHILD bill, particularly since there have been questions raised about some provisions.

From the beginning of my discussions with Senator Kennedy, my basic objective was the creation of a program that would be administered at the State level.

That concept is embodied in the CHILD bill.

Our bill is voluntary on the states. The States can decide whether to participate or not. It is not a Federal mandate. For those States electing to participate, our bill

would provide block grant funding to the States. If a State chooses to participate, then we provide significant flexibility for States to use the money as they determine.

Let me emphasize that our bill is not necessarily an insurance measure.

States will have the discretion to determine whether an insurance approach is best suited for their constituency.

For example, if a state wants to pursue the insurance approach, then they could contract with an insurance company, or companies, to develop an insurance product for children.

This product would then be made available to eligible children in the State.

Another option for the State would be a system of providing direct subsidy payments to employees who are purchasing health insurance from their employer. For example, States could develop vouchers that would be made available to low-income working families with uninsured children.

Furthermore, States could also utilize the services of Community and Migrant Health Centers to provide services directly to children.

The bottom line is that we are not locking-in a specific mechanism that States would have to implement in order to address the problem.

Our bill focuses on the poorest of the poor children not on Medicaid. primarily children of the working poor.

Of the estimated 10 million uninsured children. our bill would provide coverage for approximately half of these kids. As you know. The President's budget proposes outreach efforts to enroll the 3 million children eligible for Medicaid. but not currently enrolled. Our bill does not address that segment of children: But, that is a critical component. and I intend to work with Senator Jeffords, Senator DeWine, and others on a Finance Committee proposal. I believe, and I know Senator Kennedy believes as well, it is absolutely essential for this program to work. that we must provide maximum flexibility to the States to design their programs accordingly.

The bill is not open-ended, but authorized for a 5-year period at $30 billion. Moreover, there is no individual entitlement that would create unknown and uncontrollable budgetary commitments in the future.

An important and significant component of the bill is that it contains a deficit reduction payment mechanism.

Over the 5-year period, $20 billion is designated for the program services component of the bill. In addition, $10 billion, or one-third of the total revenues, would be dedicated for deficit reduction.

The revenues to fund the program services component of the bill are raised through an increase in the excise tax on tobacco products, including smokeless tobacco.

Now I must tell you in all candor that the revenue producing component of this bill was very troublesome for me. We need to cut taxes around here, not increase them.

But I think a good case can be made that we should make an exception here. Quite frankly, taxing tobacco products achieves two beneficial results.

First, it produces needed revenues—we just can't ignore that.

And, second, it provides a strong economic disincentives for people, particularly young people, not to smoke or begin smoking. Each day, nearly 3,000 young Americans become smokers.

This is despite the fact that smoking in our country is the Nation's number one preventable cause of premature death. Approximately 48 million Americans smoke and about two million use other products like chewing tobacco; yet, tobacco kills an estimated 419,000 Americans each year.

According to a 1994 CDC report, tobacco cost an estimated $50 billion in direct health care costs in 1993. Of this total, the CDC estimated that $26.9 billion went for hospital expenditures, $15.5 billion went for physician expenditures, $4.9 billion went for nursing home expenditures, $1.8 billion went for prescription drugs, and $900 million went for home health care expenditures.

These statistics, I believe, outweigh our natural reticence to increase taxes.

Now let me just leave you with this one final thought.

I believe the 105th Congress will send to the President legislation to expand health care coverage for children.

However, such legislation will have to be bipartisan if it has any real chance of becoming law. The legislation Senator Kennedy and I have introduced provides a workable, meaningful, and bipartisan approach.

I welcome your input and analysis and remain open-minded with respect to suggested revisions.

But we have a great opportunity to work together in a bipartisan fashion and get something done for millions of children and parents who truly need our help.

Once again, thank you for the opportunity to appear before you this morning, and I look forward to working with you in the months ahead as we address this issue.

The CHAIRMAN. Senator Specter, please proceed.

Senator SPECTER. Thank you, Mr. Chairman.

I appreciate the opportunity to testify before this distinguished committee on this important subject, and I commend you, Senator Jeffords and Senator Kennedy, for convening the hearing.

There is no doubt today that the cutting edge today on the need for health care is with the uninsured children of America, and this follows the pattern which I think the Congress has wisely established, to move for incremental coverage, and it is something that I have been working on for the 16-plus years that I have been on the Subcommittee for Health and Human Services of the Appropriations Committee which I now chair.

Senator Harkin and I on a bipartisan basis have moved in a number of directions to increase health coverage generally, but specifically for children. More than a decade ago, when I was visiting the Alma Ellery Institute in Pittsburgh, I saw for the first time a one-pound baby, a child no bigger than my hand, carrying scars for a lifetime and at the enormous cost of some $200,000 or more per child. As a result of that experience, I suggested to my colleagues on the subcommittee that we start a pilot program called Healthy Start. That originated with eight units across the country, and it now has grown to an appropriation of more than $100 million. Legislation is pending for an authorization, but as we know, sometimes the appropriators move ahead of the authorizers on some of these programs. But we have taken a very decisive stand to try to provide prenatal care. As Dr. Koop has pointed out, four prenatal visit and one postnatal visit could do a tremendous amount in eliminating low birthweight babies, of which there are thousands, at a multibillion-dollar cost to our society.

In assessing this year's needs and the cutting edge, I concur with Senator Hatch, Senator Kennedy and Senator Graham, all of whom I commend, in trying to move for coverage of this group of uninsured children who fall between the Medicaid or general poverty level and those who can afford private health coverage. And I would respectfully disagree with my colleague Senator Kennedy about Senator Graham's program coming out of the Republican Caucus. I do not believe that it is fatally flawed, but I do believe it is in need of improvement, and what I think we need to do is to coalesce our forces. Senator Hatch and I were debating here in a gentlemanly fashion--we occasionally do it in a gentlemanly fashion——

Senator HATCH. All the time.

Senator SPECTER [continuing]. About who would sign onto whose bill, and I think we can come to the table and try to work it out in a cooperative way.

The essence of my program is this, very succinctly stated because of the time limitations. My bill, S. 435, the Health Children's Pilot Program Act of 1997, creates a 5-year pilot program funded with discretionary dollars, rather than a permanent entitlement, to provide block grants to the States in support of health insurance for uninsured children who are not eligible for Medicaid or for employer-based private health insurance and whose family incomes

are up to 235 percent of the poverty level, or $37,718 for a family of four.

This bill would offer full vouchers, with the level determined by the Secretary of Health and Human Services based on costs for an insurance policy covering preventive, primary and acute care services for a child in the category which I have articulated. By limiting eligibility to children who do not have access to employee-based private health insurance, this bill would avoid creating a disincentive for private coverage.

The total number of uninsured children is somewhat in doubt because of the difficulty of precise statistics. It has been estimated at up to 10 million children. The critical group as I see it is the group which does not receive Medicaid coverage but which is not eligible for private insurance coverage through their families. This group may be as low as 4 million children—I am really not sure—but I believe that that is the critical group which we should target at this time as the highest priority level.

My bill has two suggestions. One suggestion is to use the available broadcast and nonbroadcast spectrum. I know that the broadcast spectrum has been spent over and over and over again on legislative proposals, but I do not believe it has been spent at all yet, realistically, and there is no priority higher than the healthy children priority. So that when we start to spend it, I would suggest that that would be the first place to spend it.

Earlier this week, my subcommittee held a hearing on a burgeoning new concept that the critical time for learning is zero to 3, and major magazines have been featuring major articles, and earlier this week, Governor Dean appeared before our subcommittee along with Governor Voinovich to push education and health programs zero to 3, and Carl Reiner appeared at the same time to give a personality TV push to that line, because of the evidence that that critical age period is when the children really start to learn.

Mr. Chairman and members of the committee, and my distinguished colleague, Senator Hatch, when a tax is proposed, however worthy the tax may be and however worthy it may be to discourage antisocial conduct, I think it faces a real problem in the Congress of the United States. I frankly have doubts that you could pass a tax bill today which would tax organized crime. I think that this subject is so important that we ought to try to move ahead without becoming embroiled in the tax issue.

I have an alternative thought, and that is that we are searching within the subcommittee budget of $74 billion, which has to cover three departments—Education, Labor, Health and Human Services—to see if we can find some dollars in the discretionary line, and I will be asking Secretary Shalala, with whom we have been working very closely, who is doing a very able job as Secretary of that Department, to see if we can find some funds within existing lines to at least get started in the area of greatest need, and this year, when we are going to mark up this year.

We have used the authority of the appropriators—and again, this is without authorization, because the authorization process is sometimes slower—to move ahead in a number of areas.

Beyond my legislation, S. 435, I have now introduced legislation for three Congress over 5 years—S. 18 in the 103rd and 104th Con-

gresses, and S. 25 in the 105th Congress—because it is my view that we have enough resources in America with the budget at $1.7 billion to take care of America's real needs if we prioritize, and that is coverage beyond the 10 million children to the 41 million Americans who are now not covered, if we could work out our priorities. But I think that this is the number one priority, and I will be working with Senator Harkin on a bipartisan basis, as I said, in the Appropriations Committee to put dollars this year on this issue, and we will be working closely with Senator Hatch, Senator Kennedy, Senator Graham and others to try to find a comprehensive long-term solution.

Thank you, Mr. Chairman.

[The prepared statement of Senator Specter follows:]

PREPARED STATEMENT OF SENATOR SPECTER

At a Thursday afternoon press conference, the Chairman of the Senate Appropriations Subcommittee on Labor, HHS and Education, Senator Arlen Specter, R-Pa., unveiled his "Children's Health Pilot Program Act of 1997," a distinctly Republican approach to providing health insurance to the uninsured children of the working poor.

Senator Specter's bill would provide health insurance coverage to the 4.2 million American children of the working poor without expanding entitlements or creating additional Washington-based, big-government programs.

Instead, his bill would set up a 5-year pilot program, creating a $10 billion trust fund to provide States with block grants to pay for health-insurance vouchers for qualified families during this test period. The trust fund would be capitalized by the sale of Federal spectrum assets, both broadcast and non-broadcast. A full summary of his bill is attached.

Joining Senator Specter at the press conference were four members of the Brandt family of Tarentum, Pennsylvania (Allegheny County). The Brandt parents, Scarlett and Richard, earn too much money to qualify for Medicaid supports, yet cannot afford to provide their children with private health insurance.

After enduring years without coverage, the Brandt children are presently helped by a Pennsylvania State program for children's health insurance, which Senator Specter views as a model for the Nation.

In describing his legislative effort to help families like the Brandts, Senator Specter said, "This legislation will begin to fill an enormous and unacceptable gap in our support for the health and well-being of less-fortunate children.

"Providing coverage to the uninsured children of the working poor is not a Republican or Democratic issue. However, our two parties do have different approaches to the role and size of the Federal Government. This legislation will provide coverage to those who need it most, but will do so in a manner that respects our fundamentally Republican ideas of individual freedom, personal responsibility, and pay-as-you-go government."

The Problem: In the United States, 10 million children lack health insurance. Approximately 4 million of those children have parents with jobs but with too little income to purchase health insurance and too much income for their children to be eligible for Medicaid: the working poor. The next step in bipartisan, incremental health reform is a measured response to this major problem of children without health insurance. We must react with both compassion and consideration, and continue with the approach to health care reform which generated consensus support for the Kassebaum-Kennedy bill in the 104th Congress.

The Healthy Children's Proposal:

- Authorizes $10 billion in discretionary spending over 5 years for the Secretary of HHS to provide States with block grants to give vouchers to purchase health insurance for children to families earning up to 235 percent of the Federal poverty line ($37,718/family of four), with benefits phased out on a sliding scale beginning at 185 percent of poverty ($29,692/family of four).
- Health insurance provided under this program would be for primary, preventive, and acute care. Voucher levels would be determined by the Secretary of Health and Human Services.
- Funding would be subject to appropriations and would come from a Healthy Children's Trust Fund that would be capitalized by the sale of Federal spectrum assets (broadcast and nonbroadcast) and which would provide sufficient funds to prop-

erly test this approach to children's health coverage in a way that does not bust the budget.

• Phases in beginning in FY98 with State planning grants and then gradually covers additional children by age group, starting with those aged 0–5 in FY99. When fully phased in, the program would cover about 4.2 million children under age 18 in FY2002 at a cost of $3.5 billion. Congress would then have to decide whether to reauthorize the program and if so, how to pay for it.

• The cut-off level is a bit higher than median household income in the United States—$34,076. In other words, taken together, Medicaid and this new initiative would permit eligibility of income levels covering more than half of the households in our country. To go beyond that is to do what too many programs already do—tax those who have less for the benefit of those have more.

g7f States would have the flexibility to design their own voucher programs. Unlike Medicaid, this pilot program would be fully paid for by the Federal Government. Further, States which are already providing health insurance coverage to children eligible under this bill (such as under their own expanded Medicaid plans) would be required to maintain their efforts, but would, in effect, receive credit from the Federal Government in the form of dollars equal to the costs of the coverage they are providing to children in families covered by the bill.

• Eligibility is also limited to children who do not have access to employer-based private health insurance, thus avoiding shifts from private coverage.

The CHAIRMAN. Thank you, Senator Specter. We certainly want to work with you, and I hope we can all join together on "the bill" when it is finalized.

I have just one question to ask you, on a subject where I believe we agree. That is, we have the Medicaid program, which we can proudly consider to be our foundation for helping young kids. Why not continue to work only through this program, which has served as an exemplary model of Federal-State partnership? Why should we look elsewhere?

Senator SPECTER. That is a hard question, so I will yield to Senator Hatch. [Laughter.]

Senator HATCH. Well, we provided in our bill that we use Medicaid as a model. I will be honest with you—the reason we did that was because we did not want to get into what we got into in the omnibus bill over the last number of years, of every provider and ever person in the world coming in and demanding to be part of the basic benefit package. But there is no question that we have got to work with the Governors, and we are going to have to work out the language in this particular area.

Medicaid also happens to be an open-ended entitlement. I think in both cases, our bills are not. It is an expensive open-ended entitlement at that, and we cannot really afford the existing Medicaid program. Both the States and the Federal Government are screaming about the runaway costs of Medicaid, and in contrast, in the Hatch-Kennedy bill, our capped program is not an entitlement. It is a targeted approach that allows the States considerable flexibility in both design and administration, and we think we have prepared it in a way that will really work.

But there is no question that we are going to sit down with the Governors and see what we can do to work out some of their concerns in this area, but we sure as heck want to keep this from becoming an entitlement even though some would try to say that it is.

Senator SPECTER. Mr. Chairman, in response to your question, I think it would be handy if we could work it through Medicaid. The problem is that we are now taking up the budget, and there are proposed cuts in Medicaid, and we are in an experimental program,

trying to give it to the States. Entitlements are frowned up, and we are trying to move away from them. If there were any entitlement which would be worthy, I think it would be uninsured children who fall between the poverty level and those who have private coverage. But my sense is that in this period where we are trying to balance the budget and have budget reform—and there are proposed cuts for both Medicaid and Medicare—that we would be wiser to look for collateral sources of funding, and that is why I am going to look hard within the discretionary funding of the subcommittee which I chair.

Senator HATCH. Could I make one other comment on that? There are things that need to be done in Medicaid, and I happen to be aware of the fact that you are doing a bill in the Finance Committee, as I serve there as well, and frankly, we intend to support your bill. So I am very interested in what you are trying to do in this area.

There is no question—we file these bills, we take a torrent of criticism, and we take a torrent of praise, and then we sit down and work things out so we can bring the largest number of people together. It is amazing to me how some people try to make this into some sort of a cause celebre rather than trying to solve the problems.

In that regard, I want to commend you, Mr. Chairman, for being willing to face this issue in this very important committee that I happen to revere and regard very highly, to try to do something about this. That is what Senator Kennedy and I are trying to do, and certainly Specter, and I have to say that Senator Graham is doing his best to try to resolve this problem as well, as are others.

I think we ought to get rid of the recriminations. Let us all get together and try to get this problem solved—and I think we will.

The CHAIRMAN. That is one reason that I became a member of the Finance Committee this year. I believe it is critical that we all work together to develop a solution, rather than become divided by questions of jurisdiction that keep us from working as closely together as we should.

Senator Kennedy.

Senator SPECTER. Senator, you had to give up the Appropriations Committee and a spot on the Subcommittee on Appropriations for Health and Human Services. We miss you there.

The CHAIRMAN. I know, and that was a very tough choice; but I knew you were there, Arlen, so I was not worried.

Senator HATCH. We all know Arlen is there. [Laughter.]

The CHAIRMAN. Senator Kennedy.

Senator KENNEDY. Thank you

I would just say that on Medicaid, of course, the States could expand it now if they want to put the money up.

Senator HATCH. Sure.

Senator KENNEDY. But they have not been willing to put the funding up, so we get into a situation—although I, too, welcome the chance to support Senator Jeffords' Medicaid program over in the Finance Committee—where they have not put it up. You would have to put up a good deal of additional funds to get the States to put up whatever they need, which is probably right back to where you are in terms of total cost—some estimate it might even be

more. And what we have tried to do in terms of broadening the basic supports for our children's health program—because as we all know from past debates, there are those who have differing views about the Medicaid program—we have tried to work with the private sector and build upon what the States have been doing. So that has been an underlying factor in terms of our approach.

And then I just want to finally mention that, of course, we believe very strongly that the cigarette tax has the advantage not only of funding but discouraging—discouraging—young people from becoming involved in smoking. We think that that is an advantage. I know Senator Specter takes some exception to that, even though I guess Pennsylvania itself has increased the cigarette tax in order to provide for children's health programs.

But the most important thing this morning, I would hope, Mr. Chairman, is that we find ways to move this whole process forward. We have some differences, obviously. Senator Specter gives some additional perspective to this debate in other areas, which I personally would strongly support. But I think we also must be realistic in trying to figure out how we can take an important step forward and build the broadest possible coalition to achieve something which is of compelling importance, and that is the coverage of these children. I am very concerned about drawing down even in the discretionary funds the scarce resources to try to find some additional funds to finance this program, when we have scarce resources in those areas. Frankly I am quite troubled—and I know that Senator Specter differs with me—by Senator Gramm's bill, because we are reducing the Earned Income Tax Credit for working families, particularly for the 4 million working families that do not have children, an increase of about $188 a year—and we are only providing $750 million a year for maternal and child health services.

So I am for enhancing maternal and child health services, and I think we can find common areas and try to reduce some of the areas where we have differences. I think this is what we can do and, hopefully, will do.

I know we have got to move on, but I wanted to thank Senator Hatch for addressing the issue of the entitlement. In his comments, he responded to the fact that this is not an entitlement, that there is a specific mechanism written into the bill so that if the State does not get sufficient funding, they can adjust their own program within the level of funding that they have. He made it very clear that that has got to be further examined, and we would certainly do that.

I have heard Senator Hatch say many times that you do not really consider this a general tax why is that?

Senator HATCH. It only applies to those who smoke. In other words—and look, if we can discourage smoking, which the Senator brings up very well, if we can raise the price 10 percent, then 7 percent of kids will never smoke. It makes sense.

But in all honesty, on this entitlement program, we write in the bill that "Nothing in this title should be construed as providing an individual with an entitlement under this title." Now, some have argued that because this bill may be popular enough that in 5 years we will want to reauthorize it, therefore it must be an enti-

tlement. Well, that is true of every bill, then, that has any legs or any ability to do anything, so that is hardly a good argument. And others try to argue that because it is going to be effective, people will want it. And some say that if we increase the cigarette excise tax or user fee, and we start this program, and because the incidence of smoking will go down because the cost of cigarettes will go up, that there is something wrong with that. I think that that is a very good thing, because if we can get the incidence of smoking down and the addiction rate down, we are going to save an awful lot of health care costs in our society by people who abandon smoking—and certainly with a lot of these kids.

Now, if we do nothing in this area—there are 10 million kids here, and they are from the poorest of the poor families not on Medicaid; their parents earn less than $25,000 a year, many of them less than $20,000, and a lot of them are single heads of household who work, who are doing the best they can—if we do nothing about this, 5 million of these 10 million kids are going to wind up smokers, and a good percentage of them are going to be addicted to nicotine, and a high percentage of them are going to be people who cost society billions of dollars, unnecessary dollars if we do the right things now.

I know it is tough to find funding sources for these matters, but I cannot think of a better funding source than the very industry that is causing an awful lot of health care problems in our society. Senator Kennedy mentioned that the estimate is $50 billion a year. I personally believe it is higher than that. But that is just the health care. We are asking for $3 billion; we are asking for $3 billion from an industry that is costing us $50 billion a year. And in the process, I believe, over time, we will bring health care costs down more than the cost of this bill will be on an annual basis.

So it seems to me it makes a lot of sense, and I am very proud to work with Senator Kennedy and the other cosponsors on this bill.

Senator SPECTER. Mr. Chairman, I want to comment briefly.

Pragmatically, I believe that the emphasis that Senator Kennedy and Senator Hatch have just made is going to make this a debate over a cigarette tax and not over children's health. I think that that is a bad idea.

I believe that people ought not smoke. I do not smoke. I used to smoke. When I was 17, I smoked Kools, when I was a youngster in Russell, KS. I do not smoke anymore, and I like to persuade people not to smoke. But there are a lot of people who do smoke, and the question is what you are going to do as a matter of social policy to discourage people. I think we ought to try to persuade people not to smoke, but every time you talk about a tax, you draw tremendous, tremendous opposition. A lot of people in a libertarian society think that Government taxes too much now, and I frankly think Government does tax too much. As I said, if you tried to tax organized crime, I think you would have a hard time getting any tax through the Congress.

That is why I like the focus on children's health care, where we have a compelling case. In the last couple of years, Senator Harkin and I on a bipartisan basis have either consolidated or eliminated 134 programs in our subcommittee to save $1.5 billion to allocate

to NIH and education. You were there, Mr. Chairman, and you helped us do it, Senator Jeffords, on the subcommittee.

That is why I think that with the $1.7 trillion, we can assess our priorities, and this is at the top. But I really am concerned when we start talking about a tax, even a tax on cigarettes, that this program is not going to move forward and that we are going to be debating taxes and not children's health care.

Senator KENNEDY. Mr. Chairman, I have some other questions that I will submit to Senator Hatch on some of the criticisms that have been raised.

Let me just say, finally, that there are those, Senator Specter, who wonder why nonsmokers ought to be paying the bill for smokers as a matter of equity as well, and they are paying it. They pay at least $50 billion a year in medical costs directly and about another $50 billion in lost wages and productivity.

Fine, for those who want to smoke—we are not trying to prohibit it—but I think that most workers, those who are paying the tax, are also wondering why they are paying the tax for other people who want to smoke cigarettes. I think that is an issue that at least Members of the Senate ought to be able to make a judgment on without impeding on the question—we can dispose of that, and then come back to the issues of health care for children.

Let me ask Senator Hatch, finally, on this issue—Senator Hatch, I know you have studied the settlement issue. Evidently, the $300 billion, which is a big chunk of change for anyone, can effectively be paid if the cigarette companies increase their tax for a pack of cigarettes by 50 cents without very much impact in terms of lost sales. So with the 50 cents per pack, they would get $300 billion in this period of time without really much of a loss.

Do you think that that is much of a settlement?

Senator HATCH. Well, you raise a good point. I agree with Senator Specter that the emphasis has got to be on child health, but unfortunately, we have got to raise the money to pay for it, too. And it seems to me that it is the most logical source in the world to help pay for this, since smoking causes so many of our health care problems in this society.

But 50 cents a pack should produce over 25 years $300 billion. What the tobacco companies want for that is a global settlement that will basically alleviate their product liability and alleviate all the lawsuits that are going on. For that, they are willing to pay that much money.

The fact of the matter is that if you look at children's health care, what we are asking for is a very small percentage, but can you imagine the health benefits, the community benefits, the societal benefits, the Government benefits that would come from spending this modest amount of money in overall terms on children's health?

Chatting with one of the leading tobacco industry executives not too long ago, one of my friends said that the tobacco industry executive said, "I would do exactly what Senators Hatch and Kennedy are doing if I were in their shoes." And the reason they say that is because they themselves know that the industry is extremely vulnerable right now; now that Liggett and Meyers has given these revelations and these documents and these memoranda that show

that they have been enticing kids into smoking, 3,000 a day, half of whom will become addicted, and that it is much to their advantage to entice teenagers into smoking because they will continue smoking thereafter, and the profits will keep coming in.

Well, I do not want to climb all over the tobacco companies any more than we have, but the fact is and it seems to me that this is a reasonable user fee to be paid by those who actually use these products. And it is not just direct smoking that causes health care problems. We all know now, and it has been proven, that indirect smoking or passive smoking causes problems, too.

So I think this is going to take off. I personally believe that people are going to support this. It is a reasonable approach, and I hope we can get it passed.

Senator SPECTER. Mr. Chairman, Senator Kennedy has misstated my position. I do not stand for people who want to smoke. That is what Senator Kennedy said, that Senator Specter stands for people who want to smoke; and that is not my position at all, and it is a blatant misstatement. I have not said that.

And when Senator Kennedy says he would like to have the Senate work its will, I am all for that. I vote against filibusters all the time. Let the Senate work its will.

We have been at this hearing now for almost an hour, and instead of focusing on children's health, we have focused on ways to discourage people from smoking, and that is exactly wrong as to what this legislation ought to establish. If we want to have legislation to discourage people from smoking, I am all for that. I will support legislation to persuade people not to smoke. But we are spending all of our time trying to discourage teenagers and others from smoking, and that is away from smoking, and that is away from the subject.

That is why I think if we push that line, this legislation to cover children is not going to succeed.

Senator KENNEDY. Mr. Chairman, if I could speak as a matter of personal privilege on it, and then we can move on.

The CHAIRMAN. Certainly.

Senator KENNEDY. If the record says that I said that you are for smokers, then let the record——

Senator SPECTER. You said Senator Specter stands for people who want to smoke.

Senator KENNEDY. You can have your position. That is fine. I will agree with you.

Senator SPECTER. Well, do not misstate it, then.

Senator KENNEDY. Well, I am not distorting it when I say you are against any increase in the tobacco tax in order to discourage children from smoking. Are you against that, or are you for it?

Senator SPECTER. Well, I did not say that, either. I said——

Senator KENNEDY. Well, would you tell us what you would support?

Senator SPECTER. Well, would you let me finish? You asked me a question. Let me finish, let me finish.

Senator KENNEDY. Well, will you answer it? Will you answer it?

Senator SPECTER. Of course, I will answer it. I always answer your questions.

I do not think that—the issue as to whether we ought to have a tax to discourage children from smoking is something I might well support, but I am not going to support it when we are talking about children's health care, which is a red herring which will defeat us from getting the primary legislation.

I think that all the emphasis that you and Senator Hatch are putting on trying to discourage people from smoking is very good; it is excellent—but I do not think it ought to be attached as the principal object of trying to get children's health care.

Look, here—we had legislation on the floor a few years ago for motorcycle helmets and whether States ought to have the discretion, and the Senate voted to give the States discretion. Then, an amendment was offered that if people were not wearing motorcycle helmets and were injured, they should not be paid by Medicaid. And the Senate said no—they should be paid by Medicaid.

So that these are not issues which I think ought to be taken up on children's health care. When this issue gets to the floor, if it is on a cigarette tax, it is going to lose.

Senator HATCH. Mr. Chairman, just one thing. I am happy to see that the Labor Committee is still true to form; there is still lots of fire in this committee, and it is just great. [Laughter.]

The CHAIRMAN. Yes, indeed. Unless one of my other colleagues has a compelling desire to ask a question of this panel, I would like to move on to the next panel, if that is all right. [Laughter.]

Senator MIKULSKI. Mr. Chairman, I would just ask unanimous consent that my opening statement be included in the record.

The CHAIRMAN. That will be done, for you and all members.

[The prepared statement of Senator Mikulski follows:]

PREPARED STATEMENT OF SENATOR MIKULSKI

Thank you, Senator Jeffords. This is a very important and timely hearing. The health of our children is one of the most important issues this committee and this country faces. Our children are the future of this great country. Our children are our greatest resource. Our children need to be a priority. I strongly support our efforts to increase our understanding of the issues related to children's health.

During the past months, our discussions have focused on the need for health insurance for children. We all know the statistics. More than 10.5 million children are not covered by health insurance—that is 1 out of every 7 children.

In my State of Maryland, data for 1995–96 show that an estimated 385,000 children—or 29 percent—under the age of 18 went without health insurance for at least one month during this 2 year period. That is almost one-third of the children in Maryland. These are children from working families. These are children in families where parents work, but don't have health insurance benefits. These are children in families where parent make too much money to qualify for Medicaid, but not enough to pay for health insurance.

Let me give you an example. There is a family living in Southern Maryland. They have two children. The youngest has mild heart disease. The Mom quit work to stay home to take care of her children. The husband is a self-employed carpenter making $40,000 a year. They can get and individual policy, but it costs $9,000 a year.

That is almost one fourth of their yearly income! The family has a difficult decision to make. Should they go without insurance, or should the Mom go back to work?

Today we are faced with a multitude of public health problems resulting from societal changes. Increased poverty, child abuse, child neglect, poor housing, violence, guns, substance abuse, and the list goes on. In my own State of Maryland, poverty led to 168,000 children going hungry in 1993. Guns led to the death of 110 children under the age of 19 in 1993. 40,934 children were reported as being abused or neglected, and 7,332 babies were born to adolescents between the ages of 15 and 19 in 1994—in many cases babies giving birth to babies.

These major public health problems are having a significant negative impact on our children. Our children are becoming victims of circumstances beyond their control. We have not done an adequate job to protect them.

Substance abuse continues to be a major problem. Inhalants are now the "drug of choice" for 13 year olds. 1994 Maryland data show that over 17 percent of 8th graders have used inhalants. There is a mother in Baltimore who is championing a new educational program in the local schools called "For Pete's Sake—Don't Use Inhalants!". Her son Pete died last June at the young age of 15 after sniffing butane—common every day lighter fluid. Pete's mom didn't know about inhalants. She didn't know that her "good kid" was experimenting with a common, but deadly substance.

Let me turn to another issue for a moment—access for children to primary health care. School-based health centers and demonstration projects are popping up all around the country. We need to look closely at these projects. In my State, there is a school-based health center in the largest elementary school in Baltimore. It has an active community advisory board that is helping to meet the needs of their children and families. The City Health Department is also working with managed care organizations to develop sustainable reimbursement to keep it going as a viable primary health care site.

The issues surrounding the health of our children are broad, but crucial. I have only touched on a few here. But the time has come for us to be more proactive in the health care of our children. The time has come for us to make sure children have health insurance and a health care infrastructure that meets their needs.

Senator WELLSTONE. Mr. Chairman, if I could, I have a compelling——

The CHAIRMAN. You do have a compelling—all right.

Senator WELLSTONE [continuing]. But I will not ask a question, and I will just make a brief comment, because we have record flooding in Minnesota, and I am going to have to leave later, and I just want to make sure I get this on the record. I saw Mary Jane England come in, and it prompted me.

I want to say Senator Hatch, Senator Specter, Senator Kennedy and others that I am hoping that as this moves forward in a bipartisan way, we will be able to—you know, I have been working with Senator Domenici, and we have the situation where about 20 percent of children in this country really struggle with mental health problems. I do not need to tell you what the consequences of that

are. And I hope that we will be able to work in the same kind of nondiscrimination language so that we can make sure that children are able to receive this care as part of a children's health care plan.

I just want to make that clear. I know that Senator Domenici feels strongly about it, and I want to get that on the record, and if I get a chance, I will ask that question of Secretary Shalala and have her spell out what she sees. But I did want to get that on the record.

The CHAIRMAN. Thank you.

Senator Dodd.

Senator DODD. Just briefly as well, Mr. Chairman, I thank our colleagues and welcome them back to the colleagues—weren't you a member of this committee at one point, Arlen?

Senator SPECTER. No, but I would like to be. [Laughter.]

Senator DODD. Well, we would like to have you.

I would just like to point out—and I know we say this from time to time—and I do not disagree with my colleague from Pennsylvania in the sense that we do not want this to be a tax debate, we want it to be an issue that affects children; I think all of us agree with that—but let me just impress upon you—I have asked for the last 3 years for General Accounting Office studies, dating back to 1994-1995, to follow and track children's health issues, and the most recent one—I asked for it about a year ago, in 1996, and got the results back 2 or 3 weeks ago—the results show that between 1989 and 1995, 5 million additional children have lost their health care coverage. I will explain later why that has happened according to the GAO report. But there must be a sense of urgency about this, I would say, Mr. Chairman. I mean, if we go for an additional period—it is now 10 million, but private health insurance is being dropped by people, smaller employers are dropping it because they cannot afford it—so we have more and more people falling into this category. there must be a sense of urgency. I know there are a lot of priorities, but I would hope that this would be very, very high on the list. It is early enough now, and we are moving, and if we can find the common ground that Senator Hatch and Senator Kennedy have on this—and I commend both of them for it—and can seek others in this process—pride of authorship ought not necessarily be what marks this particular effort here. We ought to really see if we can in the coming weeks move on this and get it done, or we are going to find these statistics continuing to mount, and that is really my great concern.

If we have had a doubling of the amount of uninsured children in 6 years in this country, and if we wait many more years, that number is going to get higher, and the cost does not get less. So I urge my colleagues here to do what they have been doing already, but to see if we cannot come together on this bill at least in the next few weeks.

The CHAIRMAN. Thank you both very, very much. I assure you that we are going to have plenty of opportunity as we move along to continue this debate.

Senator HATCH. Thank you, Mr. Chairman.

Senator SPECTER. Thank you, Mr. Chairman.

The CHAIRMAN. Our next witness is Secretary Donna Shalala. Few people have led such a distinguished career in public service

as Secretary Shalala. In her current role as Secretary of Health and Human Services, she has worked tirelessly to improve our Nation's health care system and, thus, the lives of Americans, especially children. It is, therefore, fitting that she join us today to provide the administration's very valued input on this legislation.

Madam Secretary, it is a pleasure to have you with us again. Thank you so much for sharing your thoughts with us.

STATEMENT OF HON. DONNA E. SHALALA, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary SHALALA. Thank you very much, Mr. Chairman and members of the committee.

This is the season when life begins again. We know what changes come with spring, but what makes an infant bloom to healthy childhood and a child bloom to healthy adulthood?

As a recent Time magazine noted, we are starting to learn the answers. Or, more to the point, we are starting to unravel the mysteries of how the minds of infants and children develop. That was the purpose of yesterday's White House Conference on Early Childhood Development and Learning—to share what we know and to inspire people from around the country to find answers to what we do not know.

This much is certain—the earlier we intervene on behalf of children, the better, because the fact is that for children, health care delayed can become a healthy future denied, and none of us wants that. That is why we need to build a strong foundation for children before they are even born with strong families, safe communities and good prenatal care.

Let me say, Mr. Chairman, that Government does not raise children—parents raise children, with the help of family members and communities—but Government does have a role to play. That is why we are proposing important investments in children and families, including an expansion of health care coverage for children.

The fact is that this administration is committing record resources to children's health, with a strong focus on the unmet health needs and disadvantaged children.

I would like to briefly describe for you some of what we are doing and what we propose to do to promote the health of all children and to assure that they have access to the health care services they need.

Mr. Chairman, today, as previous speakers, the distinguished Senators, have indicated, there are more than 10 million children, one in seven, who go to bed every night without the security of health insurance. These children are less likely to see a doctor, less likely to get needed medicines, and more likely to suffer complications from treatable conditions than are children who have health insurance. Almost nine out of ten uninsured children live with working families; two-thirds live in families with incomes above the poverty line.

As the President said in his State of the Union Address, no child should be without a doctor just because a parent is without a job. And as I have frequently added, no American child should be without a doctor just because a parent has a job.

This administration's proposal is designed to cut the number of uninsured children by at least 5 million over the next 4 years. Let me quickly outline how we are going to do that.

First, we are offering a hand up to workers between jobs who need health insurance for their families while they get back on their feet. Our budget dedicates $1.7 billion next year to help 3 million workers and family members get up to 6 months of health care coverage. This will help insure 700,000 children.

Second, we are proposing $750 million a year in grants to States so that we can insure children who fall through the cracks because their families earn too much to be eligible for Medicaid, but not enough to afford private insurance.

Third, we are allowing States to provide a full year of continuous Medicaid coverage for children. We estimate that this will extend coverage to about one million children who receive Medicaid only part of the year.

Fourth, as current law already provides, we intend to add one million adolescents to Medicaid by the year 2000.

And fifth, we are working with States and health care providers in an extraordinary public-private partnership to find the 3 million children who are eligible for Medicaid but not currently enrolled.

Mr. Chairman, this is our proposal, and it has very good company. We look forward to working with you, Mr. Chairman, with Senator Kennedy, Senator Hatch, Senator Daschle, Senator Specter and others in Congress with their own legislative proposals to achieve a bipartisan goal—expanding health care coverage for children.

What is important is that we pass legislation this year. But we believe that we also need to do even more than that, and we have some other proposals in our budget, from Healthy Start, to our strategy for reducing Sudden Infant Death Syndrome, to our Healthy Child Care America campaign, to Safe Passages which focuses on the most difficult years of adolescence, to our national strategy to prevent teenage pregnancy, and to the children's mental health initiatives that so many of us have been interested in for such a long period of time.

Mr. Chairman, it is practically a truism that what unites us as Americans is far greater and far more important than what divides us. The fact is we have never been a house divided against itself when it comes to the goal of raising healthy children. We love our children. We sacrifice for them. We want to learn more about our children, how they grow, what they need, and what we can do as parents, as families and as friends to help them reach a prosperous adulthood, because if we work together, we can give every child not just a spring to remember, but a lifetime of good health.

Thank you very much. You can tell, Mr. Chairman, that I have cut my remarks considerably because of the time frame that all of you have, and I would be happy to answer any questions.

[The prepared statement of Secretary Shalala follows:]

PREPARED STATEMENT OF DONNA E. SHALALA

Mr. Chairman, this is the season when life begins again. We know what changes come with spring. But what makes an infant bloom to healthy childhood? And a child bloom to healthy adulthood? As a recent *Time* magazine noted, we're starting to learn the answers. Or more to the point, we're starting to unravel the mysteries

of how the minds of infants and children develop. That was the purpose of yesterday's White House Conference on Early Childhood Development and Learning—to share what we know, and to inspire people from around the country to find answers to what we don't know.

This much is certain: The earlier we intervene on behalf of children the better. Because the fact is, for children, health care delayed can become a healthy future denied. And none of us want that. That is why we need to build a strong foundation for children before they're even born with strong families, safe communities, and good prenatal care.

How do we achieve those goals? Yesterday's conference, broadcast to sites across the country, gave us some answers. It featured leading researchers and child experts who have spent their professional careers studying how the human mind unfolds, and highlighted model programs that support parents and improve early childhood development. The conference brought to light research and the every day experiences of parents and care givers—both of which tell us that a child's environment during the early years is critical to his or her success in school and later in life. Early intervention means less illness and disability, and more learning, development, and productivity. But the conference must be the beginning of this discussion—not the end. So I am pleased to be here during this time of renewal to talk about how HHS is helping families help their children navigate safely to adulthood.

Let me say, Mr. Chairman, government does not raise children—parents raise children with the help of family members and communities. But government does have a role to play. In particular, we must better understand the needs of children; identify which needs are not being met; and then tailor assistance to meet those needs. That is how we can help build the strong foundation children need to not just survive, but thrive.

And that is why we are proposing important investments in children and families, including an expansion of health care coverage for children. The fact is, this administration is committing record resources to children's health—with our focus on the unmet health needs and disadvantaged children.

Now I would like to describe for you some of what we are doing and what we propose to do to promote the health of all children, ad to assure their access to needed health care services.

EXPANDING HEALTH COVERAGE OF CHILDREN

No strategy to promote children's health can be complete until we can guarantee children access to the health care services they need. And this will not be accomplished until we guarantee that all children have adequate health insurance coverage.

Nearly 10 million children—one in seven—are uninsured in America today. These children are members of our communities, our neighbors. Most of these children are in working families, but millions of working parents cannot afford health insurance. Nearly 90 percent of uninsured children have a parent who works. Two thirds live in families with income above the poverty level.

Our goal is to improve the insurance and access needs of all of these children, but the costs of doing so are prohibitive. Before the end of this century we intend to make significant steps to meet that goal. Because there is no single reason why these children are uninsured, however, no single solution exists. We will need to cast a comprehensive net, working with State government as well as the private sector.

We welcome the opportunity provided by the Hatch/Kennedy Children's Health legislation, Senator Daschle's proposal, Senator Specter's bills, and other congressional efforts to dedicate significant resources for a children's health insurance expansion this year. A growing number of proposals introduced in the Senate ad House of Representatives demonstrate bipartisan support on this important issue. The stage is set for action this year. We can do it if we are willing to work together.

Medicaid

Medicaid is a critical safety net providing vital health services to low income children. It currently covers approximately 18 million children—or one out of every five. Last year, Medicaid insured 64 percent (9.8 million) of all children with incomes below the poverty level and 45 percent (14.1 million) of all children under 200 percent of poverty. Medicaid pays for about one-third of deliveries in the United States and covers over 90 percent of children with HIV/AIDS.

While children comprise over half of all Medicaid beneficiaries, they account for only 20 percent of Medicaid spending. Federal and State Medicaid expenditures for children were $30 billion in FY 1995.

For all its contributions to children's health coverage, the promises of Medicaid are not all fulfilled. Part of our efforts to expand children's health insurance, therefore, focus on strengthening Medicaid's reach.

First, we must fulfill the promise of Medicaid for children who are already eligible under current law. An estimated 3 million children currently are entitled to Medicaid coverage but are not enrolled in the program.

Through a dynamic public/private effort and in partnership with the States, we need to reach out to these children. We will seek State expertise on "best practice" models that are working to enroll children and State advice on barriers to effective enrollment, such as inadequate public knowledge and cumbersome application processes. We also will explore with States innovations that can simplify the eligibility process, such as computerized eligibility determination systems, mail-in applications and streamlined applications to determine eligibility in multiple programs. We also will reach out to private managed care organizations and insurers, public and private health care providers, advocacy groups and foundations to develop strategies to find and enroll these children.

Second, we propose that once enrolled in Medicaid, children are guaranteed a full-year of health coverage. Currently Medicaid eligibility is determined on a monthly basis. This process is expensive, cumbersome, and causes significant disruptions in access to health care for poor children. For families with incomes very close to Medicaid limits, coverage is disrupted when incomes rise even slightly. In order to guarantee more stable coverage for children, we propose to provide States with the option to permit continuous Medicaid coverage for children for one year after eligibility is determined.

Child health advocates and private health plans support this proposal. Guaranteeing 12-month continuous eligibility will improve continuity of coverage for children. In addition, it will reduce the administrative burden on Medicaid officials, health care and social service providers, and families.

Third, in addition to these reforms, we know Medicaid coverage will continue to expand with the scheduled phase-in of coverage of adolescents in families below the Federal poverty level.

State Partnership Grants

To reach uninsured children beyond the Medicaid safety net, we propose to dedicate $3.75 billion over the next 5 years in State partnership grants to help cover children in families with earnings that are too high to qualify for Medicaid, but too low to afford private insurance. We believe this program will provide coverage for an additional one million children. Our proposal builds on successful efforts undertaken by a number of States. For example:

Florida's Healthy Kids program, a school enrollment-based comprehensive preventive care program, has nearly 35,000 children enrolled statewide. Florida parents pay a sliding-scale premium; income eligibility is established through free or reduced school-lunch eligibility. To participate, children must be uninsured and ineligible for Medicaid. Although coverage is based on children aged 5–19 in participating schools, coverage is also offered to their younger siblings. The Florida program has received a grant from the Robert Wood Johnson Foundation to promote replication in other States.

Pennsylvania has expanded coverage to low-income children ineligible for Medicaid through public-private cost sharing programs—one funded by Blue Cross/Blue Shield and private donations, and the other (the Children's Health Insurance Program in Pennsylvania) funded by a State cigarette tax. The program currently serves over 50,000 children with a waiting list of over 5,000 more. In combination, the programs provide coverage for children up to age 19 in families with incomes below 235 percent of the Federal poverty level.

In July 1995, MinnesotaCare was providing coverage to approximately 44,000 children. MinnesotaCare is a publicly funded State program that covers some uninsured adults as well as children. Established in 1992, the program provides a comprehensive benefit package of coverage for children from families whose incomes are below 275 percent of the Federal poverty level, are uninsured, and are ineligible for employer-subsidized insurance.

Under our State Partnership Grant program, for children not otherwise eligible for Medicaid, States may apply for funds to initiate or expand these types of programs. States have the flexibility to establish age, income and geographic guidelines, eligibility criteria, benefits, copayments, and premiums up to the full cost of the program.

States also will be required to include features in their programs to prevent substitution of public funds for private employer-sponsored insurance. To date, State children's health insurance programs have employed a variety of such features to address the problem of "crowding out" of employer health coverage.

Workers Between Jobs

Finally, we must build on the health insurance reforms enacted last year under this committee's leadership. We must ensure that once working families obtain

health insurance, they are able to maintain coverage through periods of economic hardship without risking imposition of new preexisting condition exclusions. The Kassebaum-Kennedy health insurance reform law guarantees individuals access to coverage without preexisting conditions limitations when they move from one group insurance plan (including Medicaid) to another. People also are guaranteed access to individual health insurance policies if they have maintained continuous group coverage for a period of 18 months. Unfortunately, many families who become temporarily unemployed lose their group health coverage and cannot afford to maintain it under the options guaranteed by COBRA. Therefore, the administration proposes to enable States to extend financial assistance to purchase health insurance coverage for up to 6 months for families whose workers are between jobs. This program will provide coverage for over 3 million working Americans and their families, including 700,000 children.

EARLY FOUNDATIONS

As we work to guarantee health insurance coverage for children, we must also work to build an early foundation to anchor their lives. Through our public health efforts we can prevent disease, promote health and development, and maintain healthy communities in which our children can grow and thrive. The key to effective public health is early intervention. For children, early interventions must begin even before birth. That is why our child health programs integrate growth and development services from pre-conception to childhood, beginning with our efforts to prevent one of the worst preventable public health tragedies, infant mortality.

Infant Mortality

Although infant mortality rates in the United States have declined, we have much work left to do. For example, infant mortality rates remain disturbingly high among minority babies and in disadvantaged communities. This is why NIH continues to invest in clinical research to advance the health of young babies. It is why 34 States have exercised their option to expand Medicaid coverage for pregnant women in order to assure greater access to lifesaving and cost effective prenatal care. And it is why the administration is adopting new initiatives and expanding existing programs to combat infant mortality. Let me describe two of our key initiatives.

Healthy Start Demonstration Projects: Healthy Start demonstration grants fund an outreach program designed to reduce infant mortality in communities where the rate is twice the national average. The demonstration program, which started in 1991, is helping high risk women and families in 22 communities reporting some of the highest infant mortality rates. Healthy Start will include 30 new communities this year.

Healthy Start demonstration projects may succeed because they use the talent and experience of local residents to overcome barriers to receiving prenatal care. What kinds of barriers? Lack of awareness of the importance of prenatal care on the part of high risk mothers, as well as problems with: too few health care providers; lack of accessible transportation; and lack of clinic hours during the evenings or on weekends. Teaming up with the community has helped to lower the infant mortality rate among high-risk populations. Healthy Start also features an aggressive public information campaign to raise awareness of infant mortality and promote prenatal care and other healthy behaviors.

Back to Sleep: Sudden Infant Death Syndrome (SIDS)—the mysterious and unexplained sudden death of a sleeping baby—is the nightmare of every parent with a newborn. SIDS is the leading cause of death in infants between 1 month and 1 year of life. Although we have not yet unlocked the secret to SIDS, experts report that the position of an infant during sleep appears to be a major contributing factor. Infants who sleep on their back have a much lower risk of dying from SIDS than infants who sleep on their stomach.

Consequently, HHS recently launched an expanded public information campaign that builds on the "Back to Sleep Campaign" launched in 1993, to teach parents, day care workers, baby sitters, grandparents, and other care givers to lay sleeping infants on their backs. Our early campaign contributed to a 30 percent drop in SIDS deaths, and we intend to continue this progress. To help spread the word, Mrs. Gore has joined our campaign. And so has Gerber Foods. The company agreed to place "Back to Sleep" messages on all Gerber infant cereal boxes.

Childhood Immunization

The next step in the fight to protect children's health is immunization. Because of important scientific breakthroughs, we can now protect young children against many serious—often life threatening—illnesses. But only if children actually get the shots they need.

Thanks to persistent public health measures, access to childhood immunizations has improved significantly. And thanks to a partnership between the Clinton administration and Congress, Federal funding for childhood immunizations has doubled

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since 1992. The President's FY 1998 budget includes nearly $800 million for childhood immunization programs. Under the President's leadership we have launched a comprehensive Childhood Immunization Initiative. This initiative utilizes several strategies: (1) improving immunization services for needy families; (2) reducing vaccine costs for lower-income and uninsured families; (3) increasing community outreach, participation and partnerships; (4) improving systems for monitoring diseases and vaccinations; and (5) improving vaccines and vaccine use.

The strategy is paying off. In 1992, only 55 percent of 2-year-olds were properly immunized. By 1996, 76 percent of the Nation's 2-year-olds received the full recommended series of vaccines. Today the number of preschool children properly immunized in the United States is at an all time high. Moreover, childhood vaccine-preventable diseases are at or near record lows. For example, in 1995 the reported cases of measles were the lowest since reporting began in 1912.

While childhood immunization rates are at an all-time high, nearly 1 million children under age 2 still have not received the full series of vaccinations. One goal of the Childhood Immunization Initiative is to increase vaccination levels for 2-year-olds to at least 90 percent for 2000, for the initial and most critical doses, and to reduce most diseases that are preventable by childhood vaccination to zero by 2000.

Child Care

Millions of children spend all or part of the day in child care. That is why safe and healthy child care services are a pivotal component of our children's health strategy. We are especially pleased that last year's welfare reform bill added significant new funds for child care services and maintained the vital health and safety protections so important to quality care. Last week, the National Institute of Child Health and Human Development released new research indicating that the quality of child care helps the cognitive and language development of young children.

In keeping with this focus, our Healthy Child Care America Campaign promotes partnerships between child care providers and health care services in projects in 46 States and territories. We are in the final stages of funding the remaining States and territories, expanding the campaign to include health professionals, and issuing new streamlined model standards for States and communities.

With the number of parents entering the workforce increasing each year, this administration is committed to working with Congress and others to assure the availability of safe and healthy child care.

Head Start

The Clinton administration has made the expansion and improvement of Head Start a top priority over the last 3 years. Head Start is a proven success, providing children a step up in their development. Funding for Head Start has grown substantially from $2.2 billion in 1992 to $3.98 billion in FY 1997. President Clinton has also proposed to fund Head Start at $4.3 billion in FY 1998, keeping us on track to serve 1 million children and families in 2002.

In 1995, we launched the "Early Head Start" program to expand the proven benefits of Head Start to low income families with children under 3 years of age and to pregnant women. This initiative builds on the research base discussed yesterday at the White House Conference on the importance of early stimulation and healthy environments. We hope to serve 35,000 infants and their families next year.

All Head Start and Early Head Start Centers are required to have established linkages with health, nutrition and other social services, to ensure the healthy development of young children in those centers. In addition, Head Start and Early Head Start centers engage in Medicaid outreach and referral for EPSDT services.

Maternal and Child Health Block Grant

Approximately 17 million women, infants, children, adolescents, and children with special health care needs are provided services through the Maternal and Child Health Block Grant program. This is a Federal-State partnership, with most of the $681 million appropriated for this program being allocated directly to States to assist in improving the health of mothers and children. More than $100 million is set aside for special projects of regional and national significance in areas such as newborn genetic screening, hemophilia, and child health improvement. A smaller amount—about $10 million—is set aside for support of community-oriented programs such as home visitations, maternal and child health centers for pregnant women and infants, and maternal and child health services to rural populations.

Safe Communities

Parents shouldn't have to worry that the food or juice they give their children will make them sick or the places where they play could cause them permanent harm. Protecting children from food borne illnesses and environmental hazards in their communities is an important part of our strategy to see that all children get a safe and healthy start in life.

Food Safety: The Centers for Disease Control and Prevention (CDC) estimates that each year as many as 33 million cases of food-borne illness in the United States result in up to 9,000 deaths. These include outbreaks caused by pathogens such as E. Coli, Salmonella, Enteritidis, Vibrio Vulnzficus, and Cyclospora. For children, especially younger children, the problem is especially worrisome. The outbreak of hepatitis A among school-aged children in Michigan this month is just one of the many recent cases demonstrating the need for stronger vigilance on food safety.

To respond effectively to these food safety issues, the President has proposed a $43 million interagency food safety initiative for FY 1998. We are partnering with U.S. Department of Agriculture to strengthen surveillance systems for food-borne illnesses nationwide and to improve Federal/State coordination when food-borne disease breaks out.

Protecting Children from Environmental Exposures: The President is concerned about the health of children who live near hazardous waste sites. Children are not just small adults. Because they play outside—digging, splashing and exploring—they are more likely to come into contact with contaminants in the environment. Also, children are built closer to the ground than most adults. That means they get higher doses per kilogram of toxic dust, soil, and heavy vapors. Toxic exposures released from toxic waste sites can adversely affect or even permanently damage the endocrine, immune, or nervous systems of children when exposure occurs during critical windows in their development.

HHS is working with EPA to promote policies and practices that emphasize child health. EPA is giving special consideration to ensure that environmental health standards are protective for children. Also, EPA is working to expand community right-to-know opportunities so that families have access to vital information about children's environmental health risks. HHS is working with communities to train more doctors to recognize and treat these child health problems. They, in turn, are providing parents and teachers with more complete information on the child health issues surrounding Superfund sites in their communities.

SAFE PASSAGES

In addition to establishing an early foundation for children, we must help chart their course to navigate from childhood to adulthood—to provide them safe passages through adolescence.

Too often in the past, policymakers grouped children of all ages together. We've taken a more sophisticated approach—by tackling the unique land mines that keep many of our adolescents from making smart choices with the only lives they'll ever have.

Teenage Smoking

An overwhelming body of public health data show that young people continue to become addicted to nicotine, and that one out of every three will die prematurely as a result of tobacco use. President Clinton is taking unprecedented steps to reduce children's use of tobacco products.

Every year, tobacco-related cancer, respiratory illness, heart disease, and other health problems take the lives of 400,000 Americans—the vast majority of whom began smoking before their 18th birthday. Consequently, in August 1996, the administration approved the boldest proposal ever put forward to remove cigarettes and tobacco products from our children's lives. The goal of this initiative is to cut tobacco use among our young people by half over 7 years by reducing the ready access that teenagers have to tobacco products and by lessening the pervasive appeal that these products have for potential underage users. To support the activities surrounding this over-all goal, we propose to spend $70 million in FY 1998 to help States comply with regulatory requirements, and provide financial and technical support to States for tobacco control and cancer prevention activities.

Preventing Teen Pregnancy

Although on the decline, teenage pregnancy remains a serious problem to be addressed. Each year, about 200,000 teenagers age 17 or younger have children. These babies often weigh too little and are at high risk for death. They are also likely to be poor. About 80 percent of children born to unmarried teenagers who dropped out of high school and are poor, compared to just 8 percent of children born to married high school graduates aged 20 or older.

We also know that teens with disabilities are at very high risk of becoming pregnant or being sexually abused. Thus part of our Teen Pregnancy initiative is to identify the specials needs of these young people and develop special considerations for the programs that serve them.

In January, this Department released the National Strategy to Prevent Teen Pregnancy. This broad-based strategy includes nearly $65 million for abstinence education programs. The key principles of the strategy are: (1) Parental and adult

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involvement; (2) Abstinence and personal responsibility; (3) Clear strategies for the future; (4) Community involvement; and (5) Sustained commitment.

The Clinton administration has developed a comprehensive drug strategy, with a particular focus on preventing substance abuse by young Americans. In addition to its broad research agenda and funding for drug treatment and prevention, HHS is targeting resources toward public education of America's young people about the dangers of drug use. Our outreach strategy to the media and entertainment industries will secure their help in communicating the facts about marijuana and other illegal drugs to young people.

HHS-supported research has shown that marijuana is the most commonly used illicit drug in America. Recently, there has been a resurgence in marijuana use among 12-to 17-year-olds—with rising usage rates every year since 1991. As much a cause for concern is an increasing feeling among adolescents that there is little or no risk to themselves or others in their abusing drugs.

To attempt to reverse these trends, the Department is increasing the resources dedicated to preventing marijuana and other substance abuse. The HHS Youth Substance Abuse Prevention Initiative is working to combat these rising usage rates with an aggressive communications strategy to reach young people early with the message of prevention and opportunity. This initiative will allow HHS to mobilize and leverage Federal and State resources, raise awareness and counter peer pressure messages, and measure outcomes.

Approximately $63 million will be dedicated to State Incentive Grants in FY 1998. To qualify for these grants, Governors are required to develop comprehensive Statewide strategies for reducing youth substance abuse. In designing their plan, states may propose their own approaches but will be offered a menu of effective substance abuse prevention strategies and programs that are based on scientific research.

Physical Activity/Overweight

Another area of significant concern for future generations of healthy Americans is the growing lack of physical activity in children and the rising prevalence of overweight kids. Nearly half of young people aged 12 to 21 years and more than one-third of high school students are not vigorously active on a regular basis. Just last week, a new study was released that examined the prevalence of overweight among American preschool children from 1971 through 1974 and 1988 through 1994. This study indicated that the prevalence of overweight increased among 4-and 5-year-olds during that time. As a nation, we are failing to instill increasingly passive generations of our children with the habit of staying active and fit.

Through regular physical activity, young people can improve their cardiovascular endurance and muscle strength, help control weight and reduce fat, and help build healthy bones. Regular physical activity can also reduce anxiety and stress and increase self-esteem. If maintained into adulthood, regular physical activity reduces the risk of dying prematurely, dying of heart disease, and developing diabetes, high blood pressure, and colon cancer.

To reinstate the importance of physical activity to our overall health, the Centers for Disease Control and Prevention has developed Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young People. These guidelines will provide educators, sports and recreation professionals, health professionals, community leaders, and parents with concrete steps they can take to help young people adopt and maintain physically active lifestyles. These guidelines are being mailed to experts and professionals throughout the country to promote physical activity among young people.

Also, the President's Council on Physical Fitness and Sports, in cooperation with The Ad Council, produced a 30-second public service announcement challenging teenagers and pre-teens to make exercise or physical activity a part of their lives. In a message prominently featuring the back side of blue jeans, young people hear a message delivered in a voice they can relate to "Get Off It," and take it around the block or take it on a bike ride.

Girl Power!

Girls and boys experience some aspects of early adolescence in different ways, because they encounter different social, cultural, physiological and psychological challenges. Providing safe passages for young girls, therefore, requires strategies devised especially for them.

This year we have launched a national public education campaign called "Girl Power!" designed with input from girls themselves to provide positive messages, accurate health information and support for girls ages 9 to 14. Studies show that many girls tend to lose self confidence during this pivotal age, becoming less physically active, performing less well in school, and neglecting their own interests and aspirations. It is also during these years that girls become more vulnerable to negative outside influences and to mixed messages about risky behaviors.

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Cigarette use among eighth-grade girls has jumped 45 percent between 1991 and 1995. Marijuana use is up among our teenagers, with the rate rising faster with girls than with boys. Alcohol use is also high. Along with substance abuse comes other risks such as depression and sedentary lifestyles. These problems have a greater impact on girls than boys.

The goal of the Girl Power! campaign is to galvanize parents, schools, communities, religious organizations, health providers, and other caring adults to make regular, sustained efforts to reinforce girls' self confidence, through positive messages, meaningful opportunities and accurate information about key health issues. We currently have over 100 private and public partners, including young, visible leaders like Olympic Gold Medalist Dominique Dawes.

CHILDREN'S MENTAL HEALTH AND DEVELOPMENT

Approximately 14 to 20 percent (8 to 13 million) of all American children experience mental and emotional disturbances. Included in this group are 3.5 million youth—5 percent of the American child and adolescent population—who have serious emotional disturbances.

Children's Mental Health Services

Since 1992, the Comprehensive Community Mental Health Services for Children and their Families Program has worked with communities to plan, develop and implement comprehensive, community-based, coordinated, family-focused, and culturally competent systems of care for these children. In FY 1997, approximately $70 million will be distributed to 22 grantees—States, local governments, Native American reservations and tribal organizations—to provide an array of community-based services organized to care for children with serious emotional, behavioral, or mental disorders of sufficient duration to meet the diagnostic criteria specified in DMH-rv, resulting in functional disturbances.

These grants assist communities in developing local systems of care that collaborate mental health with child welfare, education, juvenile justice, and other appropriate agencies. The program also ensures that under-developed or non-existent services, such as respite care, day treatment, therapeutic foster care, school-based services, emergency services, and diagnostic and evaluations services, are funded.

Starting Early/Starting Smart

While significant progress has been made identifying and meeting the mental health and substance abuse needs of older children and adolescents, the needs of younger children have gone largely unaddressed. Research shows that increasingly many young children demonstrate problems with respect to relationships, emotions, and behavior, entering school with few intellectual, social, and emotional school readiness skills.

Our *Starting Early, Starting Smart* initiative seeks to fill this gap by reaching children at their most critical time for mental and physical development. This public-private collaboration will develop strategies to address the needs of young children, from birth to seven years, who are affected by alcohol, drug abuse, and mental health disorders in their families.

We know more research on this critical age group is needed. We will identify effective approaches for improving cognitive, social and emotional outcomes for children. These approaches will target the whole child in the context of the family and will include primary care and mental health, as well as substance abuse prevention and treatment for family members when appropriate. Finally, services will be comprehensive, child-focused, family-centered, and community based.

Through *Starting Early, Starting Smart*, we hoper to address these needs and create community-based partnerships to sustain improved physical and behavioral health and health care services.

CONCLUSION

Mr. Chairman, it is practically a truism that what unites us as Americans is far greater—and far more important—than what divides us. And the fact is, we have never been a house divided against itself when it comes to the goal of raising healthy children. We love our children. We sacrifice for our children. And we want to learn more about our children—how they grow, what they need, and what we can do as their parents, families and friends to help them reach a happy and prosperous adulthood.

As I mentioned earlier, government cannot step into the shoes of these individuals. But government can provide some of the tools, some of the research, and some of the support that families need to raise healthy children.

That is what we are trying to do. From prenatal care to preventing teenage smoking to expanding health insurance coverage for children and adolescents, the Clinton administration is dedicated to giving every child not just spring to remember—but a lifetime of good health.

Thank you.

The CHAIRMAN. Thank you very much. I also will try to be brief and allow you time to respond.

I think we are all very dedicated to doing all we can to help children. I know that the usefulness of many of the programs in your purview such as those at NIH, and the Substance Abuse and Mental Health Services Administration is apparent. However, the relevance to children's health of programs such as health professions training programs or the Agency of Health Care Policy Research may not be so apparent.

I wonder if you could briefly comment on the utilization of those programs and whether they need to be strengthened when we go through the reauthorization process?

Secretary SHALALA. Well, I think they do, and they are extremely important because we need health professionals who are sensitive, in the case of the health professions legislation, to cultural differences, who come from different communities and are prepared to go back into community health and into public health. So there is a range of programs.

At the Agency for Health Care Policy Research, for which we have a new director, Dr. John Eisenberg from Georgetown University, he will revitalize that agency with a specific focus on quality. I believe, along with the Children's Health Initiative that Congress will consider this year, that turning our attention to quality, to different ways of measuring quality, and to providing more consumer information and consumer protection for the programs that are currently in place, private and public, is the direction in which we will need to go in the future if we are going to maintain both the kind of fiscal integrity that we intend, but also maintain a health care system of the finest quality that this country continues to enjoy.

The CHAIRMAN. I know that you are doing what you can within your administrative powers. For instance, I know that you are working with the Environmental Protection Agency, among other efforts. I wonder if you could explain some of the various things you can do administratively to assist us as we craft legislation and also describe what your top priorities are within those administrative initiatives.

Secretary SHALALA. With the Environmental Protection Agency, we are in particular working on issues related to lead, for example, which direct affects children, as well as toxic substances. There is a whole range of programs. There is a lot of cross-cutting in the administration. HUD, EPA, and HHS, for instance, worked on the lead issues together. All of these directly affect children's health, and in fact, probably getting lead out of gasoline as Congress did not so many years ago had a major effect on improving the quality of children's health in this country—an example of a law that really did in fact make a difference in terms of the quality of children's health. We still have a problem with lead-based paint, but that is just one example of the range of things that we are doing for children.

The CHAIRMAN. I just want to make sure that as we go forward in creating new legislation, we do everything we can to enable you to use your powers as fully as possible.

Senator Kennedy.

Senator KENNEDY. Thank you, Mr. Chairman.

Welcome, Madam Secretary. We commend the President for working to make sure that the children who are the sons and daughters of the neediest people who quality for the Medicaid program and are not receiving it should. In my own State of Massachusetts, we see too many children who qualify but who have dropped off in recent times, so there is a very important reason why we should give that priority; and the sons and daughters of parents who are in between jobs is another important feature; the stimulation you are trying to give the States, $700 million a year, to get the States moving along is also very important.

We are still going to find a group that is not going to be included or covered by all of those, and they are going to need health are coverage. Those numbers are increasing, as you yourself know. Can you tell us about where caring for those children are in your own priority and the administration's priority in terms of health care coverage?

Secretary SHALALA. The children who are left out of the health care system in the United States, as you well know, Senator Kennedy, from your own bill, are those children whose parents are working, but they are too low income either to take advantage of an employer's program, or the employer does not provide family coverage, or they simply do not have the income to pay a premium. It is an access problem. They often start out on Medicaid. A parent may get another job, or their income may go up a little so they are above the line for the Medicaid cut-off. Again, working parents who cannot provide health insurance for their kids are left out of the system.

The tragedy is how well we have done in some aspects of the welfare bill where, in about half of the States, if you go through the welfare system into a job, you will be covered with health insurance for at least 2 years; in the other half of the States, you will be covered with health insurance for yourself and your kids for at least 1 year. And yet people who go directly into the same kinds of jobs would not have health insurance available to them because they did not go through the welfare system.

We need to do something about the children of low-income working parents, and I think that that is exactly what your bills propose and what the President is interested in.

Senator KENNEDY. I know you were here during the earlier discussions, and I think that even though we may have a difference with regard to the cigarette tax and the health implications for children with regard to increasing the tax, nonetheless as I understand your position, you are ready to work with us across the board, Republicans and Democrats, as we try to come up with a legislative solution to deal with that. Senator Hatch and I are still in the process of expanding the support for our initiative, but we understand that you and the administration are prepared to work with us to try to deal with those who do not have health coverage, and that you believe that that is important and it is a priority?

Secretary SHALALA. It is, Senator Kennedy, and we have no disagreement with anyone in this country about the effects of tobacco on children. The President has spoken eloquently, and we have our own regs going into place. And while we have financed our program within the President's balanced budget proposal, and we believe

our program is compatible with the Hatch-Kennedy bill and some of the other bills, we are simply prepared to work both on the design of the program and to consider the financing that might be proposed as part of this longer discussion. But we want to get where everyone wants to get, and that is to make sure that every child in this country, particularly these children of working parents who have no chance of health coverage, gets health insurance.

Senator KENNEDY. So at least the initiative that we have talked about with Senator Hatch is not in conflict with the administration.

Secretary SHALALA. Absolutely not; they are consistent.

Senator KENNEDY. Good. And would you agree with me that certainly one of the most important steps we can take this year to improve the lives of children is to substantially expand insurance coverage to the uninsured children?

Secretary SHALALA. Absolutely. It would be an extraordinary step for this country to make sure that these children who have no health insurance have good health insurance.

Senator KENNEDY. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman. I also thank you for my rapid ascent in the Labor Committee in regarding to seating. I was feeling a bit ostracized sitting in my usual seat, trying to hold up my whole side of the aisle, so I appreciate it.

Senator WELLSTONE. Mr. Chairman, I thought Senators were supposed to wait for at least a year before they could move up.

Senator DODD. Some move up in chairs pretty quickly. [Laughter.]

Senator COLLINS. I very much appreciate the Secretary's testimony this morning. I want to talk about a very intriguing statistic that was on an earlier chart which was up only very briefly.

You mentioned that one out of seven children in America is uninsured, which is of great concern to me and is one reason why I joined as a cosponsor on the Hatch-Kennedy bill, although not on the cigarette tax part.

In addition, I believe there was a statistic that 87 percent of uninsured children come from working families.

Secretary SHALALA. Right.

Senator COLLINS. That is of great concern to me because it suggests that we are doing a better job taking care of the very poor than we are of the working poor.

But then there was an intriguing chart that said that not all uninsured children are poor, and I wonder if you could comment on the 30 percent of uninsured children who come from families where it appears they should be able to afford coverage. Can you give us any insight as to why that population is not insured?

Secretary SHALALA. Well, I think that what these charts probably look at is a range of poverty, and these children will be somewhere in the lower middle-income group; they may just bounce out of the system. They are simply not at the poverty line or just above the poverty line, but may be just above that. That is number one.

And number two is there will always be children, because their parents are unemployed for a period of time—which the President

approaches in his own workers' bill-who are middle class; dad loses his job, they really do not have the money to keep up on their health insurance, since it is not built into their budget, so they lose it for a period of time, and they are out of the health insurance system for a period of time. So you are always going to have a certain number of people who are out of the health insurance system.

The other group may be in a place where the health insurance is so expensive—they are in a rural area, in a farm area, where it is very expensive to have family coverage because you have to buy an individual plan. So some of this is direct access, some of it is out of work for a period of time, not being able to keep up you health insurance in the system. The point is that everyone ought to have access. All of us are talking about voluntary programs.

Senator COLLINS. I suspect that part of that group is also children living with parents who are self-employed and do not buy insurance coverage, and that is one reason why I support 100 percent deductibility for self-employed individuals.

Secretary SHALALA. Right.

Senator COLLINS. Another issue—you mentioned in your written testimony that 3 million children are eligible for Medicaid, and yet they are not enrolled. When I think of my State, I know of people who, while working, are poor and really struggling to make ends meet. Their children would be eligible for Medicaid, but they view Medicaid as a welfare program, and because of their pride, they do not enroll their children.

Can you suggest some ways that we could remove the stigma, if you will, or make it easier for them to enroll, and also expand more specifically on what you are going to be doing with Governors to expand and to reach that population?

Secretary SHALALA. I have two answers to that. No. 1—pass one of these bills that gives the money to the States so they can design a program flexibly and put their own identity on it. You are about to hear from Governor Dean of Vermont. That is precisely what he has done with his "Doctor Dinosaur" program, with a big publicity campaign—I do not want to take his thunder away—where people did not identify that program with a poverty program. So that is number one—flexibility to the Governors; they put their own name on it; it is designed as a program for working families.

The second point I would make is that a lot of families who are in Medicaid now do not realize they are eligible, or their incomes bounce around. One of the things that I hope Hatch-Kennedy and some of the other plans will look at is a simple proposal that we have that we learned from Head Start. In Head Start, if you are enrolled in Head Start, and your mom suddenly gets a job that gets you above the income level, you stay in Head Start for the whole year. We did not want to pull the kid out of Head Start. We need to do the same thing for Medicaid. Once enrolled in Medicaid, we ought to keep the children there for the full year and then they can be transferred to the new State program if they are over the income limit.

The importance of that is that some of these 3 million either bounce around the income level, or it is identified with the stigma of poverty. But the transition may be as important for picking up a number of million children as actual new programs that the Gov-

ernors design themselves. So I hope that this committee, working with the Senate Finance Committee, will worry about that a little bit. It has worked very well for us in Head Start.

Senator COLLINS. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wellstone.

Senator WELLSTONE. Thank you, Mr. Chairman.

First of all, a couple of observations and then a couple of questions on mental health, Madam Secretary. For the record and for the benefit of others here—and Governor Dean will talk about Vermont—in Minnesota, I think we have really led the Nation. We cover children up to 275 percent of poverty. This has been extremely successful and commands widespread support in the State of Minnesota. This is absolutely, if you will, the right thing to do.

Second, some questions that have been raised about the Hatch-Kennedy bill, and we are going to get some testimony from public health people here today. I do think that we should think about covering uninsured pregnant mothers. I think the whole issue of prenatal care is so critical and is very much a part of this focus on what we need to do from the very beginning. So I just want to raise that as a question.

I also want to express some skepticism, even though I think that may be, if you will, the political compromise and maybe a very good compromise—I am all for getting something done—about whether this should be optional. I think the argument that can be made is that this is a matter of national community responsibility to make sure that each and every child has decent health care coverage so that each and every child in our country can reach full potential. I do not know whether we ought to make it optional or not, but those are the questions that I would raise.

On the mental health part——

Secretary SHALALA. Senator Wellstone, Medicaid is now optional. No parent is forced to enroll his or her child in Medicaid. I think that is what we are talking about here in the word "optional."

Senator WELLSTONE. I am talking about whether States participate in the program.

Secretary SHALALA. Well, Medicaid now does not require every State to participate in the program. Arizona, in fact, has a different program. But they all end up doing this in one way or another. I cannot imagine a State, and I do not know of a Governor who does not want to move into this area given the opportunity to put some resources into it.

Senator WELLSTONE. I absolutely hope that that is the case, and that is not going to be my inquiry today. I understand that full well. I just said that I think it is an issue of national commitment, and I hope that every State will do it, and whatever we can do to make sure that happens is what I want to do.

A question for you. Again, on the mental health front, I think you are well aware of the statistics that two-thirds of our children and adolescents who are really struggling—and we are talking about 11 million children in this country—do not receive any care at all. I have here a quote from Dr. Steven Hyman, the director of NIMH, talking last year in testimony before the House Labor-HHS

Appropriations Subcommittee, that children and mental illness is a "national emergency."

I wanted to ask you whether it would be fair to assume that—and I think I ask this question on behalf of Senator Domenici as well—the administration was very supportive last year in making sure there was no discrimination here—is it fair to assume that the administration would be pushing hard to make sure that we do not have any discrimination also when it comes to mental health coverage for children in a children's health care bill, that we have the same parity?

Secretary SHALALA. We would do what is consistent. I think Hatch-Kennedy would cover any group here already, so we already have the law on the books. What we would have to worry about a little are the individual policies, probably. But all of us expect to have a package that is similar to the Medicaid package of some kind, so I think we could work through any issues that are not already covered by Hatch-Kennedy.

Senator WELLSTONE. And if—and I think Senator Kennedy has been a champion in this area, but just to put the question to you—if we need to work out the language to make it crystal clear that we will not have a kind of, if you will, discrimination here in which the mental health coverage of children will not be included in what we say is health care coverage, we would get good support from the administration on that, I would assume?

Secretary SHALALA. We have been consistent in this area, as have all the sponsors of all of these bills, so I think that we would want to be consistent with what we have done already for children within the Medicaid package.

Senator WELLSTONE. Madam Secretary, based on your own experience—and that was a "Yes" answer, it sounded like to me; that is what I take it as——

Secretary SHALALA. Right.

Senator WELLSTONE [continuing]. Because the President and you were very supportive last year, and seriously, just to focus on this for a second—and I think I know where my colleagues on the committee stand on this—but this is a bit of a national scandal. We have two-thirds of our children who are struggling with mental illness—not a small number of children—who really do not receive any care at all, and the consequences are devastating for those children, for families, for communities. And we certainly want to make sure that if we are now going to talk about health care coverage for children, that we include mental health coverage as well.

So again, I would hope we would have very strong support from the administration in ending this discrimination—and I think you agree. That is the way I take your answer.

Thank you.

The CHAIRMAN. Senator Mikulski.

Senator MIKULSKI. Thank you, Mr. Chairman.

Secretary Shalala, one of the reasons I have so enjoyed working with you is that not only have you long experience in managing large and unwieldy organizations, but you come out of a street and neighborhood organizing background, and this then takes me to a series of questions that I have.

I think that as the committee ponders how best to serve the needs of America's children, we have the long-range goal of providing universal access, and the Kennedy-Hatch bill will go a long way in that. While we are working on that long-range goal—and I believe it will take more than one session, or at least 1 year to move a complex bill—my question then goes to the short range.

How can we this year focus on advancing through existing programs a very specific, targeted way that we can work on a nonpartisan basis, being able to advance improving children's health care, particularly through the public health models we have? What would you say are the top priorities, and essentially it is supporting what Senators Jeffords, Kennedy, Hatch and the rest of us want to achieve, but it is also a very important point that Senator Specter raised. In this year's appropriation, what can we do to really be able to do that, and what would you recommend as the top five areas on which to focus?

Secretary SHALALA. Well, in addition to new legislation that will help expand health insurance, I think that what we have said is that we need to make an extraordinary effort to find the 3 million children who are eligible for Medicaid and do not now get Medicaid. That is not easy to do, and it must involve every community-based organization that we fund and work with across the country—every child care center, every school, every community center, every Head Start center—wherever children congregate, we have got to make an effort to identify those children and get them enrolled in Medicaid in a very systematic way.

In addition to that, our community health centers, which are places where these programs operate, our WIC programs, our maternal and child health programs—we need to make sure that the funding streams continue in those programs so that we maintain the connections of public health to children, particularly children who do not have easy access to health care providers.

Senator MIKULSKI. So that what you are saying is that part of bringing poor children into a health care delivery stream is identifying the 3 million children. Is there a national directive coming out of the White House?

Secretary SHALALA. We are in the process of putting together what I would describe as a long-term campaign with every element of the Department, including the Department of Education, working very closely with the Governors, to put all of these pieces together.

One piece that would help us is the one I just referred to. If, when you enroll a child in a health plan, you can keep him there for a year, we get another group of health plans that help us to find the children, because right now, if that child is dropped after a month or two, there is not a lot of——

Senator MIKULSKI. Secretary Shalala, how about if you enroll a child in a Head Start program or in school, that you need to identify where your children's health care is?

Secretary SHALALA. Yes.

Senator MIKULSKI. Let me come back——

Secretary SHALALA. And in fact, a combination of school identification and enrollment—we do it now in Head Start, but we need

to expand it to every place where young mothers and children are located to find the children.

Senator MIKULSKI. I would like to really encourage urgency in this, and this then goes to the utilization issue. I think the efforts of Senator Hatch and Senator Kennedy, Senator Dodd, Senator Jeffords and others, have a long history here of really wanting to expand access to universal care. But you and I know that access does not necessarily mean utilization. And therefore, while we are working on the 10 billion kids, the 7 billion without health insurance, we have a whole host of other children who either have Medicaid or are eligible for Medicaid, or have health insurance where utilization does not occur. And I am looking for how we can create both a sense of urgency and a sense of outreach and a sense of organization on how to do this.

This then takes me to the question about school-based efforts. Children use health care differently, depending on how old they are. Those in Head Start need something different than those in elementary school, and you and I know that teenagers need a different type of access than a 6-year-old.

What are your thoughts on expanding the ability, then, for schools to really be a partner or be the actual point of the delivery of at least preventive health care and certain elements of primary care? I would like to put a nurse practitioner, or several of them, in every school in the United States of America, backed up by a sophisticated team.

Secretary SHALALA. Last week, I visited a school in Washington, DC that does exactly that; it has an advanced practice nurse in an "adolescent wellness center," which is what they call it, in the high school. In that center, they offer a full range of services——

Senator MIKULSKI. We know that, but how are we going to do this? In other words, everybody can tell me individual anecdotes, but individual anecdotes do not add up to a national policy or a national organizational effort.

Secretary SHALALA. Right, but those decisions are individual public health decisions in communities. The public health block grant program is used for these programs. We have a number of demonstrations program through the Medicaid program in HCFA to expand school-based health programs. The new proposals both from the President and from Senator Hatch and Senator Kennedy will allow the States to build on different ways of organizing health care delivery, and that includes doing it in schools as an appropriate place to provide health care services.

Senator MIKULSKI. Madam Secretary, my time is up, and I just want to do two things. One, I want to thank you for approving the waiver for Maryland that enables us to put Medicaid kids in managed care, thus giving them a medical home so we know; and then, number two, your whole career has been involved not only in social programs, but social movements. And I think we need a "social movement" attitude to create the energy and vitality to get these 3 million kids in and the political will to do the other 7 million, and I look forward to working with you.

Secretary SHALALA. Thank you very much, Senator.

The CHAIRMAN. Senator Dodd?

Senator DODD. Thank you very much, Mr. Chairman, and thank you, Madam Secretary, for being with us, and we also welcome Governor Dean, whom we will hear from shortly. It is a pleasure to have both of you with us.

I will ask unanimous consent, Mr. Chairman, to include some opening comments for the record and that of Senator Harkin also.

The CHAIRMAN. Without objection, so ordered.

[The prepared statements of Senators Dodd and Harkin follow:]

PREPARED STATEMENT OF SENATOR DODD

Mr. Chairman, let me first take this opportunity to thank you for convening this hearing on an issue of long-standing concern to myself and many other members of this committee—the health status and health insurance coverage of children.

The link between children's health and insurance coverage is, in my view, very clear we know that insured children are more likely than those without coverage to receive primary care, immunizations and treatment for injuries

For several years now, I've been keeping a close eye on trends in health insurance coverage for children. I regret to say that with each passing year I become more and more alarmed at the direction in which these trends are heading.

In 1995, I requested a report from GAO on medicaid and children's health care coverage. That report indicated that a substantial number of uninsured children, 2.3 million, were eligible for medicaid, but were not enrolled and thus were unable to benefit from the critical services this program provides.

Another GAO report released in 1996 contained even more disturbing news—the percentage of children without health insurance was at its highest point since 1987. In fact, 14 percent or 10 million children were uninsured. In my home State of Connecticut alone, 80,000 children, or 1 in 10 were uninsured.

And in the most recent GAO report from February of this year, we learned that between 1989 and 1995, 5 million children lost employer-sponsored insurance coverage. (see chart) The reasons for this varied—many companies do not offer dependent coverage. Some of those that do charge rates that many employees cannot afford. Whatever the reason, more children now go without care.

In addition to the issue of children's health care, I remain very concerned about the impact of welfare reform on the health and well-being of America's poor children.

Mothers on welfare may lose coverage for their children as they move into low-paying jobs that don't offer insurance.

I am also gravely concerned and dismayed that the welfare reform legislation will result in 135,000 disabled children losing their 551 benefits, and for many, their medicaid benefits as well since SSI confers automatic eligibility for medicaid.

At the confluence of these disturbing trends and policies are the 10.5 million children who continue to go without the healthcare they need. I know that we can do better.

I am encouraged by the enthusiasm with which my colleagues on both sides of the aisle have approached this issue. I look forward to hearing from the witnesses today and to working with them toward ensuring the health of our children.

PREPARED STATEMENT OF SENATOR HARKIN

Mr. Chairman, first I would like to thank you for holding this important hearing. I can think of few more important topics for this committee to be considering. Ensuring the health and well-being of our Nation's children is one of the most important and cost-effective investments our society can make. This hearing affords us the opportunity to consider different proposals and to discuss concrete ways we can help children gain access to comprehensive, quality health care.

Back in 1994—when it became clear that comprehensive health care reform was deadlocked—I proposed a compromise approach, what I called a "down payment" plan.

I said: Let's at least provide the self-employed with 100 percent tax deductibility. Let's have insurance market reforms like portability. And most importantly, let's cover kids. Since then, we've achieved some of those goals and we've moved forward on the health care front. But one thing hasn't changed. Today—as in 1994—kids are being left behind.

As the author of the '94 kids health plan, I wish we could have passed it then. We should have. But I am pleased that it is now a top Democratic goal—and that it has now become a bipartisan effort.

There are almost 10 million children in our Nation without health insurance. A recent Families USA report listed 234,000 Iowa children as uninsured at some point in the past 2 years. And their numbers are growing—children are, in fact, the fastest growing group among the uninsured.

More often than not, these children are not from the poorest families. Nine out of ten children without insurance live in families with working parents. Two-thirds live in families with incomes above the poverty line. And three in five live in two parent families. And the sad truth is, when families don't have health insurance for their children, they are less likely to seek the wellness or preventive care children need to grow up healthy, active and strong.

Too many American families are like the Harris family of Atlantic, Iowa. Larry Harris works at a construction company and Mrs. Harris is a self-employed small business consultant. Larry Harris has insurance through his job—but the children aren't eligible. And the family simply can't afford extra coverage—so the kids must go without.

That's just not right.

Children in America have a fundamental right to education, and they ought to have a fundamental right to affordable health care.

Something is seriously wrong when prisoners have a right to health care, but kids don't.

Like the proposal I put forward in 1994, I believe we have to approach this with reason and common sense. I am pleased to see representatives of the private sector at this hearing, because I believe we must take a public-private approach to solving this problem. Because all of us—government, businesses, communities and families—recognize that if kids don't have a healthy start, we pay a heavier price down the road.

I like what I see in many of the children's health proposals that have been put forward this year. We need to take a close look at which proposal will ensure that the most children get covered. And we all need to join forces to move the best proposal forward.

I thank you, Mr. Chairman, for holding this hearing, and for recognizing that kids need coverage and working families need a helping hand. Let us stay united behind one goal: Every child in America should have quality, affordable health care.

We shouldn't close the books on this session of Congress until we've achieved that goal.

Thank you.

Senator DODD. I have stated this in the past, but I think it deserves being repeated, and I do not say this as a source of argument, because I am sure the Secretary agrees with it, but it is stunning to me. Just to give you an idea, while the rest of the country has been enjoying sort of a boom, and things have been going well, a lot better, over the last 6 years of growth, my State has lagged behind economically for a lot of reasons, which I will not go into this morning. But to give you some idea of what we may be up against here when we face the inevitable downturn economically, Connecticut, despite its per capita earnings—the highest in the country—ranks as the third fastest State in the number of children who are losing health coverage. One out of eight children has lost health coverage in the last 5 years in my State, and our economy has not been great.

So that when I point to these statistics behind me here, which we just got back from the General Accounting Office—the third such study on children's health that we have done now in 3 years—you see that 5 million children in 6 years have lost private health insurance. And that is with a relatively good economy. the economy is pretty good in the country. Imagine, if you will, that we end up with unemployment numbers that begin to move up, simultaneously with people going off welfare to work, and the jobs that are out there and the lack of health care coverage—I would just say to you that if we do not have a heightened sense of urgency about this, we are going to be looking at a problem that dwarfs the numbers we are talking about today.

So again—I have said it before—I commend my colleague from Massachusetts and the Senator from Utah and others—Senator Daschle and Senator Jeffords—for their ideas, but I am very hopeful that the administration will become just as aggressive as they have on any other single issue I can think of about this in terms of getting us together up here to come up with a proposal that we can support and move forward.

It is embarrassing when every State in this country requires auto insurance, every State in the country requires home insurance if you get a mortgage; if you go to prison in this country, you get health care, and if you get public assistance—and you may not show up for it for various reasons—but you get health care. But when 87 percent of the uninsured children in this country come from working families, and we seem to be just sort of waddling around on this thing without any sense of urgency that I think we ought to have on it.

So those are my general opening comments, Mr. Chairman, and I State them here again because I am just fearful that we are going to end up just sort of bickering about this thing, and talking about a revenue source which I think we can come to terms with and agree on pretty quickly and really move on this issue in the next several months.

Let me raise just two quick issues if I can, which were not part of your public testimony here, but I have a longstanding interest in child care, and there was a very worthwhile conference yesterday at the White House on early development of children which, with other matters up here, I unfortunately could not attend. But the National Institute of Child Health and Development, part of NIH, just did a study released last week, which you talked about in your prepared remarks, which found that the quality of child care influences the cognitive and language development of children. I am very interested, and I tried with the welfare reform bill to get more quality into the child care programs. And again, we all know the tremendous demand for child care which is going to increase, but how do we ensure that the quality of care is not going to deteriorate? And this study certainly reinforces everything that many of us have been saying for years. That is one.

The second issue about which I am gravely concerned—now, this is not a large number when we talk about 10 million kids—is that 135,000 disabled children are going to lose their SSI benefits. In fact, Eunice Kennedy Shriver wrote I thought a very eloquent piece a week or so ago in The Washington Post on this, and I was stunned by it. In fact, I think I sent you a letter immediately, but I bring it up here today—and again, it is not a huge number; it is 135,000. But these kids will lose their SSI benefits because of a change in the definition of disability brought about by welfare reform, and I suspect you can get unanimous support up here to do something on this if it requires legislative action.

So I am anxious to hear your response about what is being done immediately to see to it that these families with these disabled kids are going to be brought into the system as a result of being dropped out of it because of the welfare reform legislation.

Secretary SHALALA. On health care for the SSI kids, we have put restorations in our budget for this year. We believe most of those children are going to requalify for Medicaid because of their income levels. For those who do not, we have put a restoration request into our budget, and we will fight for that restoration for those children.

Some of the SSI kids, because they are going to be requalified individually, will requalify under another category. As you know, it was the mental impairment piece that was redesigned by Congress.

Senator DODD. Yes.

Secretary SHALALA. Social Security is in the process of reviewing every case, but we intend that all of the children who are currently on SSI will be bale to continue their Medicaid at a minimum, either qualifying at an income level or qualifying because they were on SSI previously, and we want to continue them at least on Medicaid for those who are currently on SSI.

Second, on your point about the children who have been left out of coverage or are losing coverage, the connection between employ-

ment and health insurance is starting to come apart. The importance of the bills and the flexibility in these bills is to put it back together, to go back out for workers and try to figure out a way to fill these gaps. It is exactly what Senator Collins was asking about—who are these children? Their parents are employed; their employer drops the health insurance or shifts more of the cost onto the employee, which is the other thing that is happening in the system.

Senator DODD. Yes. That is what this GAO report—and I will get you a copy of this study—there was a spike of 18 percent in 1 year in health care costs. Now, in the last couple of years, health care costs have been relatively stable. We had 29 million people in 1993 who lost health insurance, either because their companies could not afford to keep it any longer because of the cost, or they shifted the burden to the employee to such a degree that it went up to $150 or $200 a month, and they just could not afford to do it. They had decent incomes, but given the number of kids they had and so forth, they just fell off the tracks.

I would like you to comment quickly on child care, too, if you could.

Secretary SHALALA. On the child care issue, we are increasingly concerned about two things. No. 1, Congress decided to leave most of the requirements for child care quality to the States. The States came in and argued that they could take care of the quality measures; they would set them up themselves. All of the new studies are showing that we have serious problems in quality. And as we put more money out there, it is being spread more thinly. We do not have a firm fix yet on what has happened with the new child care money that you worked so hard to get into the welfare bill and whether the States are now pushing out, as anecdotal information would suggest, this exact group—these low-income workers who did not go through the welfare system.

Senator DODD. They are being pushed out.

Secretary SHALALA. One of the things that the President announced yesterday is that he will have a White House Conference on Child Care to call attention to the quality issues in time for the budget discussion, his own budget discussions. But I think the important point is that we will be up here, both reporting on what we know on the quality issue and, as soon as we can, reporting on the money issue in terms of what is happening in the States.

Many of the States are adding more money. The extra money that they had as a result of the downturn in their welfare load, they are adding more money for child care. The issue is are they simultaneously focusing on quality as we did in Head Start, where we said the new money, a substantial part of it, had to be allocated to improve the quality of that program. But that is the issue.

Senator DODD. Yes, well, they are not doing it.

The CHAIRMAN. Senator Harkin.

Senator HARKIN. Thank you very much, Mr. Chairman.

Madam Secretary, let me again welcome you and thank you for all the efforts you have been making over 4 years and continue to make this year in extending as much as you can within the budget confines we have given you and the appropriations that we have given you better health coverage to both preventive health care and

the Centers for Disease Control and Prevention, and to other entities to give to our kids. I think you have done a remarkably good job. I just wish we had the appropriations to really let you do what you have been doing in a broader sense. But I guess that is what this bill is all about is trying to find a mechanism whereby we can really cover all of these kids.

I have two thoughts. First, on the Healthy Start program, again, I applaud what you are doing there in expanding that Healthy Start program and making sure that it is funded. Second, you are proposing that once kids are enrolled in Medicaid, they extend it for 1 year, and they do not have to requalify month after month. I think that that is a step. Can you do that administratively; can that be done?

Secretary SHALALA. No.

Senator HARKIN. Do we have to take care of that?

Secretary SHALALA. It will require legislation to allow us to do that. Again, we have a very consistent record on Head Start in terms of us understanding and on the ability to get the plans to help us find the children. I think it is a simple step that is a critical piece of what this committee will do, and while it will cost a little bit of money, it will make such a difference in being able to fit all of these things together.

Senator HARKIN. Again, Mr. Chairman, I think that that is something we ought to be about this year. I suppose that comes under the jurisdiction of the Finance Committee.

Secretary SHALALA. I think it does, and it would be the connecting piece.

Senator HARKIN. We really ought to get that done, and that leads into the second thing that I want to bring up. Under the welfare reform bill, if you are a mother, and you go off welfare and take a job, your children will continue to be covered by Medicaid for an additional year.

Secretary SHALALA. And in 26 States, for 2 years.

Senator HARKIN. I was unaware of that. In 26 States, it is 2 years?

Secretary SHALALA. Yes.

Senator HARKIN. That is because they have agreed to fund it for an extra year; is that right?

Secretary SHALALA. Yes, and they have asked for a waiver to be able to do that, yes.

Senator HARKIN. To do the 2 years.

Secretary SHALALA. Yes.

Senator HARKIN. Do you think many more States will be coming in to extend it to 2 years?

Secretary SHALALA. Yes, I actually do.

Senator HARKIN. Well, that blunts a little bit of what I was going to say, just by 1 year, because I strongly felt that when people got off welfare—we know that one of the biggest reasons why people get back into the welfare system is for health care coverage for their children. So these people get off welfare, mostly women, they go to work in low-income jobs—they are the working people that you are talking about with children—and they get 1 year of coverage—okay, they get 2 years of coverage in some States. But if you have two or three children, and they are 3, 4, 5, 6, 8 years old,

and you are out in the workforce for one or 2 years, and all of a sudden, they are dropped, and you do not have health care coverage, you are going to leave that job and go back on welfare to get the Medicaid coverage.

I think this is something that is just waiting to happen out there. We may see a little blip where people are getting off welfare, but give it one or 2 years, and people with kids are going to be right back in the system again.

Secretary SHALALA. I think that that is why many of the Governors see this proposal as consistent with what they are trying to do in welfare reform—make work pay, so that people can go directly to the job and be better off, as opposed to stopping and going through the welfare system.

Senator HARKIN. That is why I said before that I believe one of the biggest forces for us providing universal health care coverage for kids is going to be our Governors out there, especially those Governors who touted the welfare reform bill so heavily. When they see these people coming back into the system because they do not have health care coverage for their kids, they are going to be knocking on our door, saying, "You had better do something."

Senator DODD. That is child care; they will want child care money, too.

Senator HARKIN. Well, they will want child care money, too, but they will want this health care money because it is going to eat into their budgets for the additional Medicaid coverage in those States.

So I think we are going to have some support out there that we may not have envisioned in terms of getting this kind of legislation through.

Finally, community health centers. We talk a lot about outreach, and we know that often, it is available, but poor families do not access it. Community health centers have done a great job in that regard with outreach programs, going out there and finding these people and getting at least preventive health care for these kids. And I hope that in our debates and deliberations and in what you do, Madam Secretary, we give more emphasis to those community health centers out there.

I wonder if you have any thoughts on that?

Secretary SHALALA. I think that they, combined with Healthy Start programs, where they use outreach workers—and Mohammad Akhter is here, and I know he agrees with me—the whole public health institutions have got to be rethought. We have got to get back out on the street. The reason why we are bringing TB numbers down in this country, and starting to deal with the AIDS issue particularly is that we are getting back on the streets with outreach workers. We are standing there while people are taking their pills in some cases, but we are also bringing in pregnant women; we are going door-to-door. Those kinds of programs will make as much difference in improving the quality of health as almost anything else we do. We need fewer people inside buildings and more people out—in Senator Mikulski's tradition—more people out there, organizing, bringing people in, identifying programs they can participate in.

The importance of home visits as part of a child care network support system cannot be underestimated, because once you walk into the house, you see other needs that can be connected up with the kinds of services that are available.

So that you will see us increasingly enthusiastic about anything that gets people out and reaching out to bring people in for services, to connect them up to the programs they are eligible for, as well as to be supportive of them as they are moving into the workforce.

Senator HARKIN. Well, that is what our community centers are doing out there, and they need more support in that regard.

Secretary SHALALA. Yes.

Senator HARKIN. I will just close by saying that I see our next witness is Governor Dean of Vermont, and I know that you have looked at his program up there. I believe they have expanded the Medicaid program to cover all the kids in Vermont, and all I can say is that if Vermont can do it, the rest of us can do it, too.

Thank you, Mr. Chairman.

Senator DODD. Mr. Chairman, just a comment if I could, quickly, on Senator Harkin's point on the community health centers and Healthy Start.

Congresswoman DeLauro and I last week were in the Fairhaven Community Health Center in New Haven, and I just cannot tell you what a fabulous job these community health programs do. And you ought to know that the Healthy Start program—I am sure you do—is a great success. It really works.

Senator HARKIN. How many new ones are you doing this year, Healthy Start?

Secretary SHALALA. About 30.

Senator DODD. I just cannot tell you what it means. Again, the people who are on the streets, who are actually delivering and working with this, just rave about it and what a difference it has made in the prenatal care and so on.

Secretary SHALALA. It is also very much like Head Start. It starts some people in the neighborhood out with jobs. What I like about it is that it hires people from the community, so it ties all of these things together.

Mr. Chairman, I know you are about to move on to Governor Dean, but let me simply reiterate that what I want to say on behalf of the administration and the President in particular is that we want to get to the same goal. We are flexible in getting to that goal. We have put some ideas in our own proposal, and we have financed it within the context of a balanced budget, but we very much want to work with you. We want to make sure as we end this century that one of our singular achievements is that every child has health insurance and in particular that parents who go to work know that their children are covered and have good health insurance.

The CHAIRMAN. Senator Kennedy.

Senator KENNEDY. Just 20 seconds, Mr. Chairman.

Madam Secretary—and I appreciate the work of Senator Dodd, who has been the real leader on the issue of child care—when you are evaluating the differences, take a look at where the differences are between what was developed by the Finance Committee, what

came out of our committee in the block grant—about $1.1 billion this year—and the program in the Armed Services. What happened was that on our bill, as Senator Dodd will remember, there was a long debate, a filibuster, and we eventually had to reduce many of the requirements protecting children.

We took the Dodd bill that came out of the committee, with all of its restrictions and protections, and added that to the defense authorization. Six weeks later, the same U.S. Senate voted that out 94-6—the same Senate that would not provide those protections for working folks. And the program in the Armed Services now is number one.

So I would hope that you would just look back at what was done and what came out of the Congress in terms of protecting children, and you will see that the dramatic contrast in the treatment started with the disparity that came out of this institution. And the program that we have in place today in all of the armed services—some of them are doing better—is the one that came out of this committee. And that is the way it should have been done. We can study and look at all the others, but I would have one of your people track that, because I think you will find that those protections are the key, and that is what we ought to be doing, with the administration's support, to make sure programs for working families have those same kinds of protections.

I thank the chairman.

Senator DODD. I just want to underscore that point. We have some kids, obviously, in child care settings. They get the money, and the money goes to subsidize the cost. And particularly in poor neighborhoods, you do not get as much choice. In more affluent communities, there is as lot of choice, and you can shop. It is very difficult to shop for child care in the poorest sections of our country, in the rural and in the urban areas.

And if we do not insist upon quality, Madam Secretary, if there is not some way that we can tie in these dollars with quality, you are going to find tragedy after tragedy after tragedy in this area, and we are going to be subsidizing it.

Senator MIKULSKI. That is right.

Senator DODD. So we have really got to insist upon this. I know the Governors will tell us, and we do not like to hear this stuff, but it is not being done locally. There is a cost factor associated with it, but if you do not do it, you will really have a huge problem on your hands.

Secretary SHALALA. And as the research that we heard yesterday reveals, if you do not do quality child care, the parents are literally putting their children at risk in terms of their growth and development. We can expect parents to go to work and take care of their families, and at the same time, we have got to make sure that we play a very strong role working with the States to maintain quality places for their children to be while they are at work.

The CHAIRMAN. Madam Secretary, thank you. I just want to assure you and Senator Dodd that we on this committee intend to take up the issue of quality child care, and I intend to develop legislation that will require the Federal and State Governments to work in alliance.

I would also point out that my bill before the Finance Committee provides incentives to States to have a 12-month enrollment, and we will continue working on that.

Secretary SHALALA. Thank you.

The CHAIRMAN. And further, just a comment. The population for whom we do absolutely nothing with respect to tax incentives is the working poor who are employed by businesses that provide no health insurance. We help virtually everybody, and as Senator Collins pointed out, we are helping the self-employed now; but to those people who work for a business that has no health insurance, we give no deductions for health plans or other consideration. So I intend to look at that issue and place it in a legislative context, especially in the Finance Committee.

Secretary SHALALA. A good issue.

The CHAIRMAN. Thank you very much.

Secretary SHALALA. Thank you very much for your leadership.

Senator DODD. Mr. Chairman, while Governor Dean is coming up, I want to note that one of the top assistants to Secretary Shalala, Rich Tarplin, who used to work with us on this committee, and since we have CSPAN here today, I want to note that there is a new Tarplin—I want you to see Joshua and Sam. Joshua is age 3 months, and he is the littlest one. Congratulations, Rich—and Linda—more importantly, Linda.

The CHAIRMAN. Governor, welcome. It has taken a long time to get to you this morning, and we appreciate your patience very much.

The Governor is also a doctor and, therefore, he inspires more respect, perhaps, in these areas than others might. He has been a national leader in health care and children's programs, and, due in large part, to his efforts, Vermont ranks second in the Nation in the number of children with health care coverage. So I offer you my personal thanks for looking out for our kids.

It is a pleasure to have you here to share with us what Vermont has done and what we need to do in order to do a better job.

Thank you very much, Governor. Please proceed.

STATEMENT OF HON. HOWARD DEAN, GOVERNOR, STATE OF VERMONT

Governor DEAN. Mr. Chairman, thank you very much. I want to try to condense a 20-minute presentation into 5 minutes, and I have no doubt that I will be successful.

Just to address the child care issue for a moment, I will say that we are a leader on that issue, Senator Dodd. And what we do and what you might want to consider exploring is we give a bonus to all child care centers that are NAEYC-certified, so they get 5 percent above the going rate—we tried to make it 20 percent, but we did not succeed—but that is something that can be done that does not run afoul of flexibility problems with the Governors.

Senator DODD. Congratulations. So we may not be back here again in the next set of hearings that Jim has on child care.

Governor DEAN. Since I have a limited amount of time, let me briefly tell you what we do in Vermont, and let me set the stage a little bit. Our economy, as Senator Dodd pointed out, in New England was about as bad as California's, and everyplace else was

doing great, so that what we did was in a backdrop of not increasing taxes but reducing taxes and a backdrop of reducing expenditures.

What we did in 1992 was expand Medicaid, essentially, in a program called "Dr. Dinosaur," where we now cover every child in the State under the age of 18 at 225 percent of poverty or below. For a family of four, that is $35,000 a year. We did that without raising taxes; we did that while we were cutting the budget and cutting what at that time was the highest income tax in the country.

The results have been startling. We combined that with an outreach program, so that we visit every family, or offer to visit to every family, within 2 weeks of the birth of a child. We hook up with them in the hospital, and we offer to visit, and 88 percent allow us to come to their homes, 12 percent refuse.

With the two things that we have done, those programs—and we did not have to raise a tax for either one of them—we have reduced our teen pregnancy rate by 20 percent, our child physical and sexual abuse is down 30 percent. No other State in the country comes anywhere close to that. We are first in immunizations in the United States, and we indeed do have a higher percentage of insured children than any other State except Hawaii. There could be some others that are close, like Minnesota, but they do not provide health insurance up to the age of 18; they provide it up to the age of 6. So that even though their percentage is higher at 275 percent of poverty, they in fact insure a higher percentage of uninsured children because they do not take that coverage up to 6.

Let me explain the secret. It is dirt cheap to cover children. For the difference of opinion in the President's budget, between where the President and the Congress were last year, you could have insured every child in the country under the age of 18 at 300 percent of the poverty—that is $46,000 a year for a family of four.

The question I have is: In a country where we are willing to cover everyone over the age of 65 without regard to ability to pay, why are we unwilling to do the same for children under the age of 18? It is not expensive. The expensive children—the $100,000 kid with cystic fibrosis or a severe disability—are already covered with the waiver program under Medicaid. To add these children to the ranks of the insured is extraordinarily inexpensive.

We did some work last September, and I presented a plan which would expand this to the national level, simply an expansion of Medicaid. We calculated that it would cost $9.7 billion. I think it would cost substantially less than that because the numbers that we used were based on the notion that it would cost about $1,000 per child under the age of 18. That is wrong because that included all the $100,000 kids who are already in Medicaid. So the real average for insuring kids, who are basically healthy kids—and I mean adolescents as well—I think is probably close to $200 or $300 per child.

So I am very excited by the Hatch-Kennedy bill. I have contacted Governor Leavitt of Utah, and we have spent a lot of time talking about it; Senator Kennedy and I have spent a lot of time talking, and Senator Kennedy's staff. I do not know what the best way is to get to this, and I did not come here to presume to say, but I know that we were able to cover Medicaid to cover all children in

families of four earning $35,000 a year or less, and we were cutting taxes and cutting the budget while we were doing it—not because I am a big fiscal conservative, although everybody at home seems to think I am, so I will continue to hold that——

The CHAIRMAN. It is all a matter of relativity.

Governor Dean [continuing.] That is right—but because we had to in order to preserve our job base and to get through and balance the budget, which we were required to do, we had to make some tough decisions. But we were able to add things while we were making those tough decisions, and one of those was children.

So I would submit to you that perhaps the way to solve Senator Specter's problem with the cigarette tax is to simply accept the President's budget on defense, and instead of adding the $10 billion, simply use that to pay for health insurance, as Senator Hatch, Senator Kennedy and others have recommended.

I do not know what the best way is to fund it. We did raise the cigarette tax in Vermont. We also cover all adults under 150 percent of poverty. That is to begin to tackle the self-employed who are very low wage, the farmers, for example, in some cases, to begin to tackle single moms who work in convenience stores whose kids will be covered by "Dr. Dynasaur," but they will not. So we did raise the cigarette tax, and there was universal acceptance of it except by the lobbyists, of course, but we found that there was no public resistance to that whatsoever—in fact, most people approved of it, and in fact, even the majority of smokers approved of raising the cigarette tax in order to pay for health care for kids.

So again, I would not want to insert myself into the politics of this body, but I believe that the cigarette tax is not an unpopular tax to raise, except perhaps within the confines of the Beltway, and although we did not have to use it to cover children, it certainly seemed to us to be a reasonable source or way to fund health care expansion.

Thank you very much, Mr. Chairman, for allowing me to come.

The CHAIRMAN. Thank you. I would like to get a little more into the record about "Dr. Dynasaur." I know how well the program has done, but let me ask you a couple of questions.

Has the phenomenon known as "crowding out" occurred in Vermont with respect to "Dr. Dynasaur"?

Governor DEAN. Yes, it has, and my somewhat cavalier answer is: So what? I encourage it as a Governor. And the reason is because it does happen that children are so cheap to insure that it has had almost no impact on our State budget at all. It is a phenomenon which we have definitely seen.

I am one who believes that as a long run goal, we ought to have a health care policy so that everybody is insured, but we certainly ought to guarantee our children the same insurance that we guarantee our seniors. And the crowding out phenomenon, since it has virtually no budgetary impact whatsoever, is actually used as an economic development tool. As you know, a number of people come to Vermont looking to locate businesses there, and I say we would be happy to insure their children if their workers are not paid above the going wage, because it is so inexpensive to do this, Mr. Chairman, and I just cannot tell you what the payment and the return is. Already, with a 20 percent drop in teenage pregnancy, we

have more than made our money back in terms of whatever small amount of expansion of Medicaid might have cost us.

So crowding out exists, it is not a budgetary threat in any way, and we have no concern about it whatsoever in our State.

The CHAIRMAN. Did going to 185 percent of poverty mean that all children in Vermont are now covered, and if not——

Governor DEAN. We went, Mr. Chairman, to 225 percent of poverty. There are some children who are still uninsured. The only State that has fewer uninsured children is Hawaii, which has 300 percent of poverty up to the age of 18; it is the only other State that covers more children up to the age of 18 than we do.

Senator Collins mentioned some things about outreach. IT has been a struggle because there is a tendency to associate Medicaid with welfare, and what I believe is that if you made this a middle class program, that would go away. But we have had to make special outreach programs. And I concur with Senator Dodd and Senator Mikulski and others that if we were able to have this outreach and schools and places where parents of small children gather, that would help substantially.

But the "Success by Six" piece really is that outreach. At least for that time, if the child qualifies, we can deliver that information at the time of birth.

The CHAIRMAN. Would you briefly explain the "Success by Six" program?

Governor DEAN. "Success by Six" is a program where we coordinated all of our programs. Just like everybody else, we have about 17 different agencies that deliver services to families, and most often, those families need more than one service. So the old model was they would go from door to door to door to try to put these all together. We give a little extra money to localities that are willing to coordinate all those services together, and part of that coordination is an outreach to every child born in the State.

What we do there is, of course, we enable those who are eligible to get benefits immediately, but the principal reason for that is to intervene in families that we know are going to be in trouble, and instead of identifying those families at age 5, when the child goes to kindergarten, and the teacher picks up that there is a serious problem, we try to pick up those families at age zero so we can work with those families, get them some job training, some child care, some basic parenting skills, and we work with those families so that that reduces our foster care budget, our special ed budget, on down the line.

The CHAIRMAN. I know you have before you, or at least before the Vermont legislature, the Parity in Mental Health bill, which has been a very critical and difficult issue for us in Congress. How do you think this will affect the mental health of children? Whom does this bill cover, and what does it do?

Governor DEAN. The Parity in Mental Health bill is a bill which essentially requires insurance companies to treat mental illness the same as every other illness. It is a bill that I support. I generally do not support mandatory add-ons because they do raise the price of health care to the private sector and that, of course, impacts everybody. But I do support a mental health parity bill because I think the present situation is discriminatory against those who

happen to have a disease of the brain as opposed to the heart or the kidney or the pancreas or something else.

So we already have mental health parity in the "Dr. Dynasaur" program. What we do to control our costs is managed care. Most of our kids are in managed care—or, they are not now, but they will be, and they are rapidly being enrolled in managed care. That give us predictability in terms of cost management, and it also gives the patient the ability to come before the provider with a card that has a managed care company on it, not Medicaid, so the patients are no longer identified and treated differently as perhaps they might be as Medicaid patients, because they are simply enrolled in the managed care program just as someone in the private sector might be.

The CHAIRMAN. With respect to the managed care program; what were the difficulties in establishing the program, and were there any difficulties specific to a rural State like Vermont?

Governor DEAN. A rural State is harder to put managed care into effect in. We now have a very substantial penetration—I am going to guess it is about 35 percent, although that might be a little bit high. For a rural State, that is more than normal. But we were way behind the curve in terms of the penetration of managed care.

That has now been changed dramatically as a number of hospitals come together and put together their own consortia, but we do find that that is a predictable way to maintain our Medicaid budget and not allow it to go out of control.

The CHAIRMAN. I certainly want to commend you and thank you for all you are doing for Vermonters.

Senator Kennedy.

Senator KENNEDY. Thank you.

Thank you very much, Governor. We have benefited enormously here this morning and in our own conversations and with your leadership in health care as Governor. You have just provided remarkable leadership which all of the States are benefiting from and we are benefiting from here as well. I am looking forward to continuing to work with you and the Governors as we move, hopefully together, to ensure that the children who are uninsured are covered. You have had remarkable experience up there in Vermont and great insight into some of the problems, and I think you have really demonstrated what works and what does not.

Many of these issues that we have been talking about here, people might have an opinion about, but you have demonstrated what actually can work and the difference that it can make to these children.

Do you feel as a doctor, and now as a Governor, that discouraging children from smoking cigarettes has a positive impact on them?

Governor DEAN. Yes, Senator, I most certainly do, and I concur with Senator Hatch's view that as the cigarette tax goes up, the number of kids who smoke goes down. That is very important, and that is probably the only age group that that is true of. I think those who argue that using the cigarette tax is a declining revenue—we have used the cigarette tax, and we find that to be untrue. We have lost a lot of cigarette sales across the border into New Hampshire, and our revenues from the increase in the ciga-

rette tax are still so substantial that we raised our threshold from 100 percent of poverty to 150 percent of poverty, which we were allowed to do administratively about a year and a half before we were scheduled to do it. But the literature does show that there is one age group that is very, very sensitive to price, and that age group is children.

So from a public health point of view, I would most certainly support increasing the cigarette tax.

Senator KENNEDY. That is certainly our conclusion, and I think you spell out that you get the revenues which are necessary to cover these children, and it also has the other aspect of having a positive health impact on the children themselves. That is very, very important as well.

In terms of how you are working with the schools themselves in terms of getting health care to the children, we have talked about school-based systems, and actually, that was one of the features of the health care reform program that had bipartisan support that we reported out of our committee. You run into different problems with it on issues of family planning and others, but how are you dealing with it in your own State?

Governor DEAN. We would like to be doing a better job, frankly. There are a number of children who are not enrolled in our program who are eligible, and we are not sure exactly why. We do some outreach through the school systems, which of course is the best way to get them.

I think that over time, what you are going to see is that the most successful outreach is the "Success by Six" outreach because it gets the mothers involved immediately at the time of birth, and then they hear about the program right away. We have about 8,000 babies born each year, so I would expect that to work its way up.

We are doing all the usual outreach things that people do, but I think the "Success by Six" intervention is going to be the key.

Senator KENNEDY. You look after expectant mothers; we permit 5 percent of the funding going to the States to take care of expectant mothers. We have not been able to reach out as much as I would have liked to in working through that. But you were able to do that through, I guess, the Medicaid waiver, were you?

Governor DEAN. In the "Success by Six" piece, the reaching out does not require a Medicaid waiver. We do not actually fund services, we fund coordination, and the local people get together with a little bit of extra money that we give for coordination and use the services they already have in the community and simply decide which professional is going to make a visit to which particular family. So it does not require very much extra money at all to do "Success by Six."

We do have a Medicaid waiver that allows us to put our welfare population and our Medicaid population into managed care, and I will not go into the details of it here, but they have to have choice and so forth; and it does allow us to charge copayments for those individuals at the upper end of the eligible. We see no reason to give free health care to people making $35,000 a year or less for their kids, so we do charge a copayment, and that is allowed under the waiver.

Senator KENNEDY. We have had a chance to talk with you about our program in general terms. Do you think that it could be a vehicle to address the unmet needs in other States?

Governor DEAN. I do. I have been somewhat dismayed that there are some people in the other party who have opposed it based on some apparent misinformation. For example, I was told yesterday by a Governor for whom I have a great deal of respect that this is a mandate and that it is an entitlement. And today, as I look through the language of the bill, it says very specifically in the bill that this is not construed to be an entitlement of any kind and whether you sign up for this program as a mandate.

I am sure that we can come to some agreement with members of the other party who are sincere and want to see children's health care advance, and I know there are members who have signed onto your bill, and I know there are other members who have not signed onto your bill who are very interested in this.

There are Governors on the other side of the aisle who want this to move and may have some constructive suggestions, and we would be delighted to work with them. I think we need this, and we should move it forward.

Senator KENNEDY. Well, you are a voice of great authority and knowledge about these issues. Having your support for this approach—obviously, not that some of this cannot be altered or changed to make it more effective—is extremely important, and I think it will be very, very important in terms of its success.

Thank you very much, Governor. They have been very helpful comments.

The CHAIRMAN. I want to take a little bit of time, at some point, to go over the "Success by Six" program and see if that could be generalized in some of our legislation.

Senator Dodd.

Senator DODD. Thank you very much, Mr. Chairman.

Let me join in this chorus of praise, Governor——

Governor DEAN. May we bring you back to Vermont for this chorus, Senator?

Senator DODD. I would be delighted to, having been there a number of times with you already over the last number of years. I am not objective at all when it comes to Howard Dean. I think you are a terrific Governor, and you have done a terrific job, and you are national treasure because of what you have been able to do in your State. And on numerous occasions, as the chairman knows, you have been willing to come down and talk about what you are trying to do. So I thank you immensely for your involvement in this issue. Obviously, you bring a great deal of credibility to it not just because of what you have been able to achieve as a matter of public policy, but the fact that you are a doctor. Obviously, we benefit on this committee with the presence of Bill Frist, who is a physician, and I think it is an asset to have people who have that kind of hands-on experience when we have discussions and debates, and we can turn to a colleague in our case here on the committee and have the benefit of a physician's knowledge. The fact that as Governor of a State, you can bring that kind of knowledge—when you walk into a room of people who do not understand the issues and can really look at it from a fiscal standpoint which is not unimpor-

tant, but also bring the kind of knowledge that you do as a result of your background—I think helps tremendously in the debate. So we are going to urge you to stay engaged in this with us, which really brings me to my question.

Many might say that Vermont is a small State and, if you do not mind the word, rather homogenized—being a dairy State, I suppose you can relate to that—but a population that is very environmentally conscious and aware, with a high degree of literacy and awareness, and so forth. When you get to States that are far more diverse and have far greater spans of economic success—not to suggest that you do not have your pockets of poverty—but they say, "Vermont is just different. That is Vermont. That is easy to do," and that doing it on a national basis is far more complex.

How do you respond to that, and second, how did you answer your critics? I mean, this did not just happen that you got up 1 day and said, "I have a great idea," and everyone joined on. I presume you went through an awful battle with people who were suggesting horror stories as to what the implications would be for Vermont. I wonder what those horror stories were and how you addressed them.

Governor DEAN. Let me give you a little bit of background about Vermont. Although we are very proud of our dairy, our largest employer is IBM, which imports and exports computers, makes chips, etc, etc.

Senator DODD. This is on your time now; this is not a Chamber of Commerce meeting. [Laughter.]

Governor DEAN. I only say that because we are not as atypical as we would like the tourist public to think as they come and visit our beautiful State. We do have our pockets of poverty, we have drug problems, we have teen pregnancy problems and all the other kinds of things that everybody else has around the country.

We are not terribly racially diverse. I give a longer version of this talk around the country, and that is an issue that always comes up, often first.

Communities are communities, and it really does not matter what ethnicity they are, and it really does not matter what size they are, but "communities" is what you have to define. Now, Vermont happens to be a community—the whole State happens to be a community—but we did not try to do this in the whole State all at once. We picked two communities that we thought would work. We did not pick the worst-off place, the most awful place that we could think of, because we wanted someplace where some local leadership could make it work as far as "Success by Six" goes.

We took 4 years to put the program in place.

On the insurance side, it was a terrific battle, and I actually battled a number of people in my own party who thought it did not go far enough and would not vote for it, and some people on the other side who thought it went too far and would not vote for it. So politics was politics, and the usual things went on, and we finally got the bill through.

Today you could not find anybody—I had a conservative Republican come up to me and say, "I have never voted for you in my life, but I am going to do it this time because my brother makes $25,000 a year, and he cannot have insurance for himself, but he

has the peace of mind to know that his children have health insurance." This is a universal issue that cuts across all parties and all races. Everybody in America believes that children ought to have health care coverage, and they are not afraid to spend money to do it. As it turned out, we did not have to spend much money.

What I would suggest, if the Congress were going to do this, is, as Senator Hatch and Senator Kennedy have recommended, let the States run the program, let the States decide whether they want to be in or out; let them have the flexibility that is in the Hatch-Kennedy bill. And I would suggest that in the small States, you can do this just as well as we can. You can do this in Utah just as easily as you can in Vermont; you can do it in Wyoming, you can do it in New Hampshire. You can probably do it in Connecticut—maybe not. Maybe what you do in Connecticut is you divide the communities; you divide Hartford into three or four different places and have a different team in each one.

The key is size. Should this be a blanket, one-size-fits-all program run out of HHS or run out of the State capital? No, it should not. Should it be targeted, the "Success by Six" piece, at individual community-by-community, to get the outreach that you need? Yes, it should.

However, I do believe that at the Federal level, it is proper and sensible to guarantee the health insurance piece, because what we are talking about is in a State, we do it all one-size-fits-all for health insurance, and then we go out and, family by family, we make sure everybody knows the benefit is there. So that in terms of the benefits from organizing the community, the fact that Vermont is a homogenous State is really irrelevant. The fact that it is a small State is very relevant. But every State has communities; this can be done city by city, borough by borough in Manhattan, in terms of the outreach. But I do believe that as a national priority, we ought to have an overarching program to guarantee insurance for kids.

Senator DODD. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Governor. We look forward to working with you on this and many other——

Senator KENNEDY. Mr. Chairman, could I ask one final question?

The CHAIRMAN. Yes.

Senator KENNEDY. What would happen to a politician in Vermont who advocated repeal of that program today?

Governor DEAN. They would be thought to be a right-wing crazy.

The CHAIRMAN. Or a left-wing nut; I am not sure.

Senator DODD. They would be looking for other work.

Senator KENNEDY. The point is that when we finally get this passed for children, I think the final result will be, as your answer suggests, that people will just ask why it took so long. And I think Vermont has shown that it is because of your leadership that you are well ahead of the rest of the country. So congratulations, and thanks for appearing.

Governor DEAN. Thank you, Senator.

The CHAIRMAN. Thank you very much, Governor.

Our first witness on the final panel is Dr. Mohammad Akhter, who is executive director of the American Public Health Associa-

tion, which is the oldest and largest organization of public health professionals in the world. Dr. Akhter specializes in preventive medicine and quality improvement matters. I look forward to hearing his testimony.

Next, I will turn to Dr. Antoinette Eaton. Senator DeWine is very sorry that he could not be here and wanted me to give you his regrets. Unfortunately, he had commitments which made it impossible for him to be here. Dr. Eaton serves as director of governmental affairs for Children's Hospital in Columbus, OH, and is medical director of the Easter Seal Rehabilitation Center there. Dr. Eaton's distinguished career is centered in care for children with special health needs and in health care financing. Thank you for joining us today.

Dr. Palfrey, I think Senator Kennedy wishes to introduce you.

Senator KENNEDY. Thank you very much, Mr. Chairman.

I am just delighted to have the chance to introduce Dr. Judith Palfrey, who is chief of the division of general pediatrics at Children's Hospital in Boston. Her credentials are extensive. She has earned national recognition as a dynamic advocate for children and families. She is the first incumbent of the T. Berry Brazelton Chair in Pediatrics at Harvard Medical School and Children's Hospital, and she has spent 20 years advocating and caring for children and families.

On behalf of the committee, I want to thank her very much for coming and tell her that we look forward to hearing from her.

Thank you very much.

The CHAIRMAN. Thank you.

Dr. Akhter, please proceed.

STATEMENTS OF DR. MOHAMMAD N. AKHTER, EXECUTIVE DIRECTOR, AMERICAN PUBLIC HEALTH ASSOCIATION, WASHINGTON, DC; DR. ANTOINETTE PARISI EATON, CORPORATE DIRECTOR OF GOVERNMENTAL AFFAIRS, CHILDREN'S HOSPITAL, INCORPORATED, COLUMBUS, OH; AND DR. JUDITH S. PALFREY, CHIEF, DIVISION OF GENERAL PEDIATRICS, CHILDREN'S HOSPITAL, BOSTON, MA

Dr. AKHTER. Thank you, Mr. Chairman and members of the committee. It is indeed my pleasure to be here this morning to testify on behalf of children's issues.

Our organization includes 55,000 members on the Federal, State and local levels, working in health departments, in local health clinics, as well as providing other services. On one hand, we do health education to keep people healthy and promote health; on the other hand, our members assure that the air people breath, the water people drink, the food people eat is safe. And we also work with the communities to make sure that people take advantage of the health care services that are available.

My comments today are going to be very brief on children's issues. Our children are in good shape, but they are not in great shape because threats facing them are tremendous in this day and age. Let me name three of the big ones.

The first one is the use and misuse of alcohol, tobacco and other drugs. The second one is lack of adequate services, both prenatal and early childhood. And third is access to health care in the great-

est and the wealthiest country in the world. I will address all three of them in relationship to the Federal programs.

I have also had the distinct honor of being the director of health for the State of Missouri at one time, the commissioner of health in the Nation's Capital, and worked in Illinois and Michigan, so I speak from very grassroots experience.

First, we believe that immunization ought to be available to every child in this country, regardless of eligibility, regardless of where they live or what they do, because one sick child can make all children sick, and the children do get together in the classrooms, and they do play together.

Centers for Disease Control has a great program. We think that that program should continue to be funded at the full level, and the Centers for Disease Control should be directed that in addition to funding the actual immunization, they ought to be funding the outreach efforts, so that people can go out and provide the kind of access that will bring in those children who have not gotten immunization. At this moment, 25 percent of the Nation's children 2 years and younger are not completely protected.

My second point deals with alcohol and drug abuse treatment programs. This is a major problem for our children, a major reason for children dropping out of school, not receiving education, and getting into other troubles like contracting HIV/AIDS and other diseases.

This is an area where the Federal Government provides services through substance abuse prevention and treatment programs, and we need to continue to fund those programs. The administration has decided to take those programs right now and convert them into research programs. We think this is unwise because services in this arena are already very little compared with the need, and we need to continue to maintain the current status, which is to provide these funds to the community-based providers so they can do the preventive as well as the treatment part, especially as it deals with children and pregnant women.

And last but not least is the issue of prevention of disease among our children by providing them with health coverage. It is a major, major issue, and I say this from my own experience in many States and in our Nation's Capital. When a child, through no fault of his or her own, just happens to be born in a family that is neither too wealthy nor too poor, and is denied access to service, it is not fair. It just is not fair. We as a Government have a responsibility to do something about it. The family alone cannot do it. I know that. There are many families that are barely breaking even. The States cannot do it—and I have been a State health director; I know that they do not have the resources. It has got to be a partnership, Mr. Chairman, among the Federal, the State and the local level, where people develop this partnership to be able to provide the coverage.

I would conclude my remarks, Mr. Chairman, by saying to you that it is not only the children that I am worried about at this moment. I am also worried about ourselves and the future of this country, because we are going to be dependent—and I say this to the baby boomers—on these very children for our support, and if these children are not healthy, if we do not support them now, if we do not invest in them now, we cannot expect a return when we

need it. This country has become great because we continue to invest in our children, and I think it is about time that we take a moment, and I congratulate all three of you here for taking one giant step in putting this issue on the map. The time is now, and this is the right thing to do.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

[The prepared statement of Dr. Akhter follows:]

PREPARED STATEMENT OF MOHAMMAD AKHTER, MD, MPH

Dear Mr. Chairman and distinguished members of the committee, my name is Mohammad Akhter. I am Executive Director of the American Public Health Association (APHA), which represents a combined national and affiliate membership of 55,000 public health professionals. Earlier this year our Association's Executive Board adopted children's health as a top priority and we are committed to working with you during the 105th Congress to accomplish your goal of improving children's health status. We are honored to appear before you to discuss this important topic.

The health status of our Nation's children is good but it is not great. Approximately 10 million children in our Nation lack health insurance coverage. Almost 300,000 babies are born each year with low birthweights. Approximately one-third of mothers do not receive adequate prenatal care to help ensure that their babies are born healthy. Infections due to contaminated food and water, exposures at day care centers, and other environmental factors affect millions of American children. In the United States, 1.7 million children have blood lead levels high enough to cause decreased intelligence, behavioral disturbances, delayed development and other health problems. Asthma is the most common chronic disease of childhood, affecting 5 million children below the age of 18. Millions of young peoples lives are destroyed by tobacco, alcohol, and other drugs. Tens of thousands of young people die or become disabled needlessly every year as a result of firearms, motor vehicle crashes, and residential fires. Almost 1 million teenagers become pregnant each year. Each year 3 million teenagers are infected with a sexually transmitted disease.

To improve children's health, the Congress must address both access issues as well as adequately fund public health programs. We must expand the number of children who have health insurance coverage. Coverage alone, however, will not be enough. Public health professionals at the local, State, and Federal levels must continue to provide the essential public health services of community assessment, public health education, and surveillance to ensure that children receive appropriate health services.

The first issue I would like to address is the enhancement of our Nation's public health programs.

Historically, public health has been one of the most, if not the most, successful of the health fields in terms of its impact on the quality and quantity of life of populations. Since the early 20th century public health agencies have worked to promote health and prevent disease.

In 1900, the average life expectancy of Americans was 45 years. By 1990, the life expectancy had climbed to more than 75 years. Clinical medicine is credited with adding 5 years, while improvements in public health have been directly credited with the gain of the remaining 25 years. This dramatic gain in life expectancy can be credited to improvements in sanitation, nutrition, and housing. Specifically, major gains have been attained by improving working conditions and controlling infectious diseases through immunizations and other public health interventions. As we move toward the 21st century it is important for our Nation to begin to understand the improvements in the quality and quantity of life that public health can achieve.

The effectiveness and efficiency of public health notwithstanding, the battle for adequate funding for public health programs is an ongoing struggle. Despite the fundamental role of public health to the well-being of Americans, the United States devotes less than 1 percent of its aggregate health spending to public health.

This year this committee will undertake the reauthorization of a number of key public health programs which can make a tremendous difference in improving children's health status. While the committee has asked APHA to focus our testimony on the public health programs that need to be reauthorized this year I want to stress that there are many other public health programs that improve the lives of our Nation's youth.

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The Centers for Disease Control and Prevention (CDC) is our Nation's premiere prevention agency. CDC's immunization program is up for reauthorization this year. Immunization is one of the most cost-effective means of preventing disease. For every dollar spent on immunization as many as $29 can be saved in direct and indirect costs.

Once, universal immunization against childhood diseases seemed within reach; today almost 25 percent of 2-year-olds lack some or all of their shots. Although immunization rates among preschool children are high, many children are still in need of one or more vaccinations. Increased resources are needed to enhance CDC's: efforts to improve immunization rates in pockets of need; public awareness campaigns of the need for timely immunization; efforts to educate health care providers to avoid missed opportunities to vaccinate; surveillance of vaccine-preventable disease; investigation of adverse events related to immunization; and immunization registry systems to ensure children are age-appropriately immunized.

APHA believes that the CDC immunization program is an essential component of any strategy you adopt to improve children's health status. We urge you to reauthorize this program with the increased resources it needs to carry out its mission.

An important public health agency up for reauthorization this year is the Substance Abuse and Mental Health Services Administration (SAMSHA). The public health programs at this agency should also be considered an integral part of any plan to improve children's health status. Over 4 million teenagers use tobacco, and over 3,000 start smoking each day. More than 4 million young people are dependent upon alcohol or have an alcohol related problem. In 1995, 11 percent of young people had used an illicit drug at least once in a one month period, double the rate in 1992.

Many SAMSHA programs could help alleviate these problems if they received the necessary resources. The SAMSHA Substance Abuse Block Grants and Children's Mental Health Services program run by the agency are critical to achieving the goal of improving children's lives and their health.

The Center for Substance Abuse Prevention (CSAP) has the High-Risk Youth Demonstration Grant which targets school-age children at risk for using alcohol, tobacco, or illicit drugs 'and the Pregnant and Postpartum Women and Their Infants Demonstration Grant which supports comprehensive community-based programs to help women of childbearing age avoid the use of alcohol and other drugs during pregnancy.

The Center for Substance Abuse Treatment (CSAT) has a variety of programs designed to support treatment for one of our Nation's most vulnerable groups—women of child bearing age and their infants and children. The Residential Program for Pregnant and Postpartum Women Demonstration Grant provides mothers and their children with such services as prenatal and postnatal health care, pediatric care, and education and counseling.

Last year, the administration restructured the demonstration programs at CSAP and CSAT into "knowledge development and application" programs targeted at research not services. Historically, these programs had directly funded community-based providers filling critical service gaps for pregnant women, women with children, youth in high-risk environments, and community-based prevention partnerships. In addition to filling critical services needs these programs had a strong evaluation component that focused on individual and collective treatment outcomes. APHA believes the demonstration programs at CSAP and CSAT have been essential elements of our Nation's prevention and treatment infrastructures. Therefore, APHA urges you to continue to fund services through CSAP and CSAT programs.

The Health Resources and Services Administration (HRSA) is responsible for administering a number of important public health programs which improve child health. Specifically the agency is responsible for assuring that quality health care and public health services are available to underserved and vulnerable populations through a network of health center programs, maternal and child health programs, school based clinics, HIV AIDS primary care services, family planning, rural health, and bone marrow and organ transplant programs. HRSA supports primary care and public health training through traineeships, student loans, area health education centers, community based clinical and leadership training, and through academic programs for minority and underserved populations.

At least four important HRSA programs are up for reauthorization this year: The Emergency Medical Services for Children program; the Organ Procurement and Transplant Program; the National Bone Marrow Donor Program; and the Health Professions training and education programs. Each of these programs are important components of the Public Health Service Act and each plays a role in advancing the issue of children's health.

The Emergency Medical Services for Children (EMSC) demonstration program was created to enhance and expand the delivery of emergency medical services

(EMS) for acutely ill and seriously injured children. Each year over 20,000 children die from injuries, and millions more are treated in emergency departments. The EMSC program has been successful in providing support to States to implement components of a model EMSC system and to evaluate the impact of different aspects of the EMSC "continuum of care," which ranges from prevention to pre hospital treatment to emergency department care to rehabilitation in the community. APHA urges you to reauthorize the EMSC program with increased resources.

The Organ Procurement and Transplant Program at HRSA helps to fill the gap between the large number of people needing organs for transplant and the number of donors. There are approximately 51,000 people on the national waiting list for organs. Of this number 1,822 are children. These children are waiting for hearts, lungs, kidneys, and other solid organs. Increased resources are needed for this program.

The National Bone Marrow Donor Program contains a network of 99 donor centers, 110 collection centers, 105 transplant centers, 11 recruitment groups and a Coordinating Center that helps patients suffering from leukemia and other blood diseases find unrelated matching donors for transplant. Each year approximately 12,000 individuals are diagnosed with diseases for which bone marrow transplantation may offer the possibility of a cure. Since this programs inception in 1986 a total of 5,526 bone marrow transplants have been facilitated. Of that number 2,012 of these individuals were children. Increased resources are needed to ensure that this program can increase its outreach and enhance and expand the only, comprehensive, National Data Registry of Marrow Donors.

The Health Professions programs at HRSA are also important when it comes to serving children's health needs. These education and training programs have been successful in helping our Nation expand the supply of primary health care providers and public health and allied health professionals. They have also helped to increase the geographic distribution of health professionals and nurses as well as increase access to health care for underserved populations. Many of the health professionals who have benefited from these essential programs have served in community and migrant health centers as well as public health departments around our Nation. Many of the patients who have benefited from this care are children. This year President Clinton's budget included sharp cuts for much of the Title VII and Title VIII Health Professions programs at HRSA. We believe these cuts are unwise and will limit the capability of these programs to effectively train primary care and public health professionals.

The Agency for Health Care Policy and Research (AHCPR) is up for reauthorization this year and also contributes to improving children's health status by conducting research on the delivery of health care to children. AHCPR researchers identify the best method of delivering service and indicate what services produce the best outcome. AHCPR also compares treatment methods and reports which treatment is most effective. APHA urges you to continue to support the agency.

The National Institutes of Health (NIH) are also up for reauthorization this year. NIH is the premiere biomedical research institution in the world. NIH has a variety of programs designed to improve the health status of all Americans including children. The National Institute of Child Health and Human Development is responsible for conducting biomedical and behavioral research on child and maternal health. APHA is supportive of the ongoing research conducted by this important agency.

Federally-funded public health programs can make a tremendous difference in improving children's health status. The public health programs I have highlighted as well as many other public health programs at CDC, HRSA, and SAMHSA should be supported to help improve the lives of our Nation's children.

On the access side of the equation, APHA believes it is essential to provide health insurance coverage to the 10 million uninsured children in our Nation. Six in 10 of these children were in families with at least one parent who worked full-time for the entire year the child was uninsured. APHA is also concerned because the number of children with private health insurance coverage appears to be dropping each year. In 1994, the percentage of children with private health insurance coverage reached the lowest level in eight years—66 percent.

APHA is encouraged that several pieces of legislation have been introduced or are being drafted to address the issue of children's health insurance coverage. APHA is currently reviewing S. 525, the Children's Health Insurance and Lower Deficit Act, which has been introduced by Senators Orrin Hatch and Ted Kennedy and cosponsored by the Chairman and several other distinguished Senators on this committee. This legislation has the potential to provide health insurance coverage to 5 million children and would be a major step forward. It also has the potential to decrease teen smoking through the imposition of a 43 cent tobacco tax. In our view, the in-

crease in the tobacco tax is a public health measure that would significantly decrease teen smoking.

The Association strongly supports this legislation's goals and believes it should move forward through the legislative process. We do have a number of recommendations regarding S. 525 that we hope you will consider. First, APHA believes that states being given an option to participate in the program is a mistake. The voluntary nature of the program may further the existing disparities regarding children's health that exists between our States. APHA recommends that all states be required to participate in the programs established under S. 525.

APHA is also concerned that S. 525 neglects to provide coverage for uninsured pregnant women. Insuring pregnant women could lead to a lower infant mortality rate, healthier babies being born, and fewer health problems for adolescents. Prenatal care should be considered an intricate component of any strategy adopted by the Congress that is aimed at improving children's health status. APHA urges you to add pregnant women to the groups covered by S. 525.

We are also encouraged to hear that Chairman Jeffords will introduce the Children's Health Care Act of 1997. It is our understanding that this legislation will use the Medicaid program to expand health coverage to children. As you know, 3 million of the 10 million uninsured children are Medicaid eligible but are not enrolled in the program.

APHA believes the Medicaid program is an essential element in ensuring that low-income children are born healthy and remain healthy. Preventive services such as prenatal care for pregnant women and immunizations for children as well as needed health care and services to sick and special needs children are all fundamental components of the Medicaid program.

We believe that in any reform of Medicaid the entitlement should remain in place. APHA also urges you to keep the early and periodic. screening, diagnosis, and treatment (EPSDT) benefit package. EPSDT has played an essential role in improving children's health status. It is the type of benefit package that provides both disease prevention services as well as health care services for the sick and disabled. APHA is concerned that many proposals presently being considered to reform Medicaid could jeopardize the health of millions of children.

Every child in America should come into the world wanted and as healthy as possible. Children should have adequate access to health care. They should be free from threats of injury and violence. They should be helped to avoid alcohol, tobacco, and other drug' problems: They should be assured of a healthful environment. Teenagers should be assured of the opportunity for reproductive health. And finally, every child should be assured a healthful standard of living.

In closing, I want to express our appreciation to this committee for its efforts on behalf of public health and health care reform. Many of the gains we have made in these areas would not have occurred but for your support. We look forward to working with you in the future to improve the health status of our Nation's children.

Thank you. I would be delighted to respond to questions.

The CHAIRMAN. Dr. Eaton.

Dr. EATON. Mr. chairman, members of the committee, good morning. I am Antoinette Parisi Eaton, a pediatrician from Columbus, OH, and I am privileged to be here today on behalf of the American Academy of Pediatrics and the National Association of Children's Hospitals.

I do want to express my appreciation for this opportunity to present to you this morning.

Certainly when we talk about children's health status, we need to begin by recognizing how different children's health care needs are from adults. Compared to adults, children are more likely to experience an acute episode of illness and less likely to need care for a chronic condition. In addition, the care they will need for both acute and chronic illness will vary due to their developmental needs and their size, which change with age. For example, the organ system, bony structure, or immunologic system of a child all go through different developmental stages before reaching maturation.

In recent years, while there have been improvements in children's health, there are still challenges, such as high rates of infant mortality and low birthweight babies. But certainly one of the biggest challenges we have the opportunity to address is reducing the number of uninsured children.

As many have said, we have millions of uninsured children many more who are underinsured. Most live in low-income families who have a harder and harder time affording health coverage because, according to the GAO, as was mentioned earlier, the cost of private insurance has been increasing.

A bipartisan poll reflects these trends. Eighty-two percent support expanding Medicaid coverage to children of low-income but working parents, and 74 percent of those surveyed support creating a new program to provide health insurance to every child, even if it means paying $25 in taxes per year. Eighty-nine percent favor requiring HMOs and other insurers to give children access to physicians and hospitals that specialize in the health care needs of children. It is obvious that Americans want this problem addressed.

What happens to uninsured children? Often, their financially strapped families tend to delay or forego needed pediatric care because of the out-of-pocket expenses. Without preventive care, these children are much more susceptible to communicable and other illnesses and, once sick, have no insurance to pay for the care that they need.

Providing appropriate health care coverage for children makes sense for America. It is not only the right thing to do, it is also the cost-effective thing to do.

An important part of children's health care is the medical home concept. A medical home is a regular and ongoing, comprehensive source of health care available around the clock, 365 days a year. It provides preventive care, early treatment of acute and chronic illnesses, and the coordination of care for those with chronic or disabling conditions. At the same time, because of their unique health care needs, particularly when they are critically ill or they do have special needs, children require access to appropriate pediatric providers, including pediatric subspecialists.

Mr. Chairman, I would like to conclude with some principles for guiding efforts to enable all families to afford meaningful health insurance for their children.

All children should have access to age-appropriate, quality health care. Health insurance coverage should be extended to children and youth through age 21 who currently do not have private health insurance or are eligible for Medicaid.

Families should receive income-based assistance for obtaining such health insurance for their children.

For a health insurance plan to qualify for purchase with a Federal subsidy, that plan must offer coverage for preventive care, major medical care, and care for children with special needs, including case management services as outlined by the Academy. Both the Academy and the National Association of Children's Hospitals strongly recommend that such health care coverage be consistent with Medicaid benefits for children, including EPSDT and its commitment to providing children with medically necessary

care. In addition, qualifying plans should require no cost-sharing for preventive services.

All children need financial access to quality health care. Efforts to help finance health insurance for children from low-income families should really serve as a complement to the Medicaid program and existing private and employer-sponsored insurance.

Parents who purchase health insurance on behalf of their children with newly provided subsidies should have the ability within reasonable limits to choose their children's physician and health plan. Additionally, physicians should not be forced to contract with one particular plan in order to provide care to newly insured children. Access to the full spectrum of pediatric care, including subspecialty care, is a must.

We need to develop measures of accountability for children's access to appropriate care, as well as measures of outcome, quality and effectiveness of their care.

We sincerely believe that promotion of the principles that I have outlined will build a strong foundation for meaningful health insurance for our children and youth.

Thank you very much.

The CHAIRMAN. Thank you, Dr. Eaton.

[The prepared statement of Dr. Eaton follows:]

PREPARED STATEMENT OF ANTOINETTE PARISI EATON, M.D., F.A.A.P.

Mr. Chairman and Members of the Committee. Good morning. I am Antoinette Parisi Eaton, M.D., a pediatrician serving as Director of Governmental Affairs at Children's Hospital, Columbus, Ohio. I am here today on behalf of the American Academy of Pediatrics and the National Association of Children's Hospitals. I have been privileged to serve as a past president of the American Academy of Pediatrics, representing 53,000 physician members who are dedicated to the health, safety and well-being of infants, children, adolescents and young adults. The National Association of Children's Hospitals represents over 100 children*s acute care hospitals, pediatric departments of major medical centers, and children's specialty and rehabilitation hospitals with missions of service to the children of their communities.

Thank you, Mr. Chairman, for scheduling this hearing and inviting me to address the important issue of improving the health status of children.

Children are Unique

Certainly when we talk about children's health status we need to begin by recognizing how different children's health care needs are from adults. My whole career has been devoted to addressing children's unique health care needs. Children face many obstacles in the health care system, but one of the hardest to overcome is how most people view child health issues. Too often it is assumed that if we take care of the adults, then children will be provided for. To address the health care needs of children properly, it is important to recognize that children are not little adults, and cannot be treated as such. We must understand that physically, mentally, emotionally, in their ability to communicate and in their ability to participate in their own care, children differ significantly from adults.

Compared to adults, children are more likely to experience an acute episode of illness and are less likely to need care for a chronic condition. In addition, the care they will need for both acute and chronic illness will vary due to their developmental needs and size, which change with age. The organ system, bony structure, and immunologic system of a child all go through different developmental states before reaching maturation. Consequently, depending on age and stage of development, children will respond differently to both illness and treatment. Children's psychosocial needs also vary by age. Children are more likely to experience sudden shifts in either improvement or deterioration of their conditions. When considering therapeutic intervention, medications must be more finely calibrated, and diagnostic procedures can be more difficult. Young children, having only a limited ability to communicate, must be examined more closely to diagnose or monitor illness. They also require more reassurance in treatment and more assistance with activities of daily living.

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In recent years, I have been encouraged by improvements in children's health care such as a reduction in the rate of Sudden Infant Death Syndrome (SIDS), improved prevention of the transmission of HIV infection to infants, and improvements in some rates of immunization in very young children.

On the other hand, there are clearly enormous challenges we still must confront in children's health care, such as further reductions in infant mortality, reducing the incidence of low birth weight babies and other challenges. But certainly, one of the biggest challenges we both face and have the opportunity to address is reducing the high number of uninsured children.

Providing health insurance coverage for children has taken on a new urgency. Keeping children well and preventing illness make sense. Having a sick or injured child is one of the toughest things parents have to deal with. Unfortunately, their stress is compounded when their child has no health insurance coverage. The time has come for the United States to become a nation that makes the health and well-being of its children its highest priority. We must make health care for America's children available, accessible, and affordable. This is an achievable goal if we make child health a priority in this country.

The importance of addressing child health issues must not be viewed simply as an act of compassion. Providing children and adolescents access to quality health care, with an emphasis on prevention, is an investment in our future. As children go, so goes our country.

Current Status of Children's Health Coverage:

There are 13.3 million uninsured children and youth through age 21 in our country today (10.5 million uninsured children through age 18). Others are underinsured. They are without adequate insurance coverage for necessary treatment services and for even the most basic care needed to prevent unnecessary illness. The problem of uninsured children is real, and we believe, must be addressed.

It is important to note that those children most likely to be without health care coverage are not living in poverty. It is the children in working families, the children of the near poor, who are most likely to lack health care coverage. These families earn just enough not to qualify for Medicaid, but not enough to purchase appropriate health care coverage for their children. The Congressional Research Service (CRS) indicates that nearly 60 percent of uninsured children are members of families in which at least one parent is employed year round, full-time, and another 20 percent are in families with a parent who is employed part-time.

What are the health implications for uninsured children? Studies have shown that uninsured children are less likely than insured children to get needed preventive and other health care. The General Accounting Office (GAO) reports that children without health insurance or with gaps in coverage are less likely to have routine doctor visits or to have a regular source of medical care. When they do seek care, they are more likely to get it through an emergency room or clinic rather than a private physician or health maintenance organization. They are also less likely to get care for injuries, see a physician if chronically ill, get dental care, receive care for such common childhood illnesses as ear infections and asthma, or be appropriately immunized to prevent childhood illness.

The Challenge Before Us

As a former Director of Ohio's Maternal and Child Health program, I am of the strong view that the federal Title V, Maternal and Child Health Block Grant program, is one of the most important public health programs for children, which will continue to play an important role in the future. Medicaid is also an essential program for children. Medicaid covers one in every four children and one in every three infants in the United States. Together more than one in three children either relies on Medicaid or is uninsured, and over the last decade the number of uninsured children has grown.

Why are so many children uninsured? The majority of American children are covered by private health insurance, most often through their parent's employment. However, according to the GAO, between 1989 and 1995, private family insurance coverage declined for both children and working-age adults. Most of the decline was for the dependents of workers, especially children. During this period, the percentage of children with private health insurance dropped from 74 percent to 66 percent. According to the GAO, had this decrease not occurred, nearly 5 million more children would have had private health insurance. Children often are the first to experience the loss of private health coverage, because dependent coverage is often the first to be dropped by employers and employees pressed by the rising costs of health insurance.

There are those who suggest that expanding Medicaid eligibility contributed to the decline in the percentage of children who had private coverage. GAO indicates that, at most, only one sixth of the loss in private coverage stems from families

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choosing to substitute Medicaid for private coverage. Other studies found a lesser effect or no effect at all. In fact, the loss of private insurance among children began before Congress expanded Medicaid coverage for children, and it continues today, long after Congress ceased to expand Medicaid for children. In addition, the Census Bureau's Current Population Survey shows that an estimated 3 million uninsured children are eligible for coverage under the Medicaid program but are not enrolled. The reasons for this vary, including lack of knowledge about their children's eligibility and/or a "welfare stigma" some have placed on the program.

As private insurance premiums increase, more and more employers are dropping dependent coverage or increasing the amount of the premium contribution required of the employee in order to control costs. Additionally, employer downsizing and a shift of employment to companies that do not provide health insurance contributes to the loss of health coverage. In firms with 100 or more employees, the average monthly premium contribution for family coverage increased by 79 percent, compared to 64 percent for single coverage, over the period 1988 to 1993. These trends point to a growing problem for parents seeking to provide health care coverage for their families.

A bipartisan polling team of Lake Research, Inc. and The Tarrance Group conducted a poll in December of 1996 which reflects these trends. When asked about who has the responsibility for helping parents obtain health insurance for their children, 43 percent of the respondents chose the government, almost twice the number of any other response. 82 percent support expanding Medicaid coverage to children of low-income but working parents. Additionally, 74 percent of those surveyed supported creating a new program to provide health insurance to every child, even if it meant paying an additional $25 in taxes per year. 80 percent would continue public support for health care for children whose parents have left welfare to begin work. 89 percent favor requiring HMOs and other insurers to give children access to physicians and hospitals that specialize in the care of children. 86 percent favor regulating managed care plans to cover all medically necessary care for children. Americans want this problem addressed.

What Children Need

What happens to uninsured children? Often, their financially-strapped families tend to delay or forgo needed pediatric care because of the out-of-pocket expense. Without preventive care, these children are much more susceptible to communicable and other illness and, once sick, have no insurance to pay for their care.

Providing appropriate health care coverage for children makes sense for America. It is the right thing to do. An important part of such care is the medical home concept. The medical home goes to the very heart of the issue of quality. A medical home is a regular and ongoing comprehensive source of health care, available around the clock, 365 days a year. It provides preventive care, early treatment of acute and chronic diseases and the coordination of care for those with chronic or disabling conditions.

Every child should have access to appropriate health care. Such care includes child health supervision visits, often referred to as well-child care. Child health supervision visits are an integral part of family-focused preventive care. They are designed to monitor a child's growth and development, and identify any physical, behavioral, or psychological abnormality at its earliest stage. Such visits provide guidance to both parents and children on such topics as injury prevention and healthy lifestyles. Promoting healthy lifestyles is critical for our nation's children, particularly adolescents. Issues such as smoking, drug abuse, and violence need to be addressed.

Well-child care can provide early detection and correction of vision defects; hearing defects that can lead to life-long impairment of speech and learning comprehension; iron deficiency anemia; abdominal masses representing potentially curable tumors; congenital hip dislocation, a potential crippler; and elevated levels of lead in the blood that can lead to learning problems.

At the same time, because of their unique health care needs, particularly when they are critically ill or have special needs, children also require access to appropriate pediatric providers, including subspecialty care. No parent wants a child requiring specialized care to be referred to an adult specialist, any more than we would want a grandparent referred to a pediatric subspecialist.

Children are a Low Cost, High Return Investment

The costs of anemia, child abuse, substance abuse, preventable injuries, developmental delays and unattended malnutrition show up not only as health care expenditures, but they also fall heavily on society's ledger in the form of social services, education or correctional systems.

Yet, children's health care is a low cost, high return investment. Because most children are healthy, their health care needs are comparatively inexpensive. For ex-

ample, in fiscal year 1995 Medicaid spent, on average, $1,047 per enrolled child under 21, compared to $4,563 per enrolled adult, and $8,868 per elderly adult age 65 and above. Children under age 21 make up over 50 percent of all Medicaid beneficiaries yet they account for less than one-quarter of total Medicaid spending, including spending for children with special needs.

Congress has repeatedly sought to invest in children's health care because of the life-long return it promises from children's ability to be healthy enough to be ready to learn and grow into productive members of society.

Principles for Expanding Children's Health Coverage

The following identify several principles we believe should guide efforts to enable all families to afford meaningful health insurance for their children.

Health Care for All Children

All children should have access to age appropriate, quality health care. Health insurance coverage should be extended to children (through age 21) who currently do not have private health insurance and are not eligible for Medicaid. Families should receive income-based assistance for obtaining health insurance for children.

Age Appropriate Benefits—Quality Care for All Children

For a health insurance plan to qualify for purchase with a federal subsidy, that plan must offer coverage for preventive care, traditional major medical care, and care for children with special needs, including case management services as outlined by the AAP. Both the AAP and N.A.C.H. strongly recommend that such health coverage be consistent with Medicaid's benefits for children, including its Early and Periodic Screening, Diagnosis and Treatment (EPSDT) commitment to providing children with medically necessary care unique to their needs. In addition, qualifying plans should require no cost sharing for preventive services.

A Pluralistic System with Public and Private Insurance

All children need financial access to quality health care. Efforts to help finance health insurance for children from lower income families should serve as a complement to the Medicaid program and existing private and employer sponsored insurance. Certainly, at a time when 3 million uninsured children are eligible but not enrolled in Medicaid and thousands more may lose Medicaid coverage due to welfare reform, it is especially important that efforts to expand children's coverage strengthen Medicaid as well as private insurance.

Choice for Patients and Physicians

Parents who purchase health insurance on behalf of their children with newly provided subsidies, should have the ability, within reasonable limits, to choose their children's physician and health plan. Additionally, physicians should not be forced to contract with one particular plan in order to provide care to newly insured children. Access to the full spectrum of pediatric care, including subspecialty care, is a must.

Accountability:

Public policy should work with parents, providers, and health plans to promote and invest in the development of measures of accountability for children's access to appropriate care as well as outcomes, quality, and effectiveness of their care.

Conclusion:

The American Academy of Pediatrics and the National Association of Children's Hospitals applaud your determined efforts to address the health care needs of our nation's children and youth. Providing health care security for our children is achievable, affordable, necessary and makes good sense. If we truly care about our nation's future we must act now to ensure that our children grow up healthy and strong.

As a pediatrician, my intention today is to bring attention to the health care needs of children. Pursuing an approach that will provide appropriate health care coverage for children is really about giving children a chance to reach their potential in life. If we can invest in keeping children and youth healthy today, they can become the healthy, productive adults of society tomorrow.

Thank you.

The CHAIRMAN. Dr. Palfrey.

Dr. PALFREY. Thank you, Mr. Chairman.

My name is Judith S. Paltry, and I an the chief of the division of general pediatrics at Children's Hospital in Boston, the largest pediatric medical center in the United States.

I am a pediatrician. I do not pretend to understand politics, the intricacies of the Federal budget, or frankly, the complex legislative process. What I do understand is children, and I know from per-

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sonal experience about their health care needs. I also believe that promoting children's health is everybody's business.

Dr. Akhter and Dr. Eaton have outlined for you some of the many health challenges we face in guaranteeing the health of our children. However, there is one overriding issue that can have a significant impact on every child's health status. That is making sure that every child has health insurance.

The GAO and other studies have clearly documented the direct statistical correlation between children's insurance status, access to care and good health. What I want to show you today with some examples are the direct costs of failing to provide insurance to children—the impacts on them, their families, the entire system of care, and on our Nation as a community.

At Children's Hospital, my colleagues and I see the frightening results of the lack of insurance. We see parents delay preventive care visits, put off surgeries, even refuse to have x-rays when their children have had an accident. I have had parents apologize to me for missing vaccinations when they have been laid off from their jobs. This is a problem not only for the family—children who are not immunized, for instance, for whooping cough or rubella, present a threat to small infants, pregnant women and the general public.

The costs of not insuring our children do not devolve to the families alone. Consider the consequences of missed routine preventive care. The child with asthma develops an attack at 8 p.m. With no medicine in the house, by 10 p.m., the child is so tight that the mother must call an ambulance. At the emergency room, the child receives the care that could easily have been administered at home if she had had a preventive visit.

This scene is repeated over and over again for the 600,000 children who have asthma and no insurance. The costs of this scenario are enormous. Who pays? The child, the family, and, yes, the other insured patients who visit the hospital. They cross-subsidize this expensive, avoidable emergency care.

The parents I have mentioned all want the best for their children, but with low-paying jobs, often cannot afford the $5,000 to $6,000 a year premium for the family. Until recently, some parents were denied insurance for an even more devastating reason—because their child had a pre-existing condition. The Congress and this committee have made great strides in protecting working families and children. Last year's Kassebaum-Kennedy legislation is now removing some of those serious barriers to health insurance.

In Massachusetts, we have recently passed legislation that builds on the successes of the Medicaid program by making it available to more families. In addition, for those families who earn too much to qualify for Medicaid, the State has also expanded eligibility for its Children's Medical Security Plan, which is limited in its coverage to primary and preventive care. Of the approximately 160,000 uninsured children in Massachusetts, we hope that 80 percent of them will enroll in either the Medicaid program or CMSP.

To pay for this insurance, we raise the tax on a pack of cigarettes by 25 cents. Children's Hospital supported this approach wholeheartedly. It makes good sense for children's health as well as financial considerations.

Smoking, for instance, causes the very low birthweight that was discussed earlier. If we can stop young women from smoking, we can cut down on one of the most devastating conditions. Let me explain why.

Nicotine causes the blood vessels in the placenta to constrict so that the developing baby is not nurtured. We have been focusing all week on the development of babies' brains. One way to protect them is to stop young women from smoking.

I am pleased to see the legislative efforts which adopt this strategy, such as the CHILD initiative. This legislation targets exactly the problems facing children that we have all outlined. It expands on access by protecting the Medicaid safety net for children, including its excellent benefits and the EPSDT provisions. It then builds on top of that Medicaid safety net by insuring additional low-income children who do not qualify for Medicaid. Medicaid is the single largest insurer of children. The full benefit package is crucial to the well-being of children because it has been designed precisely to meet their unique needs, including medically necessary care.

Enactment of the Hatch-Kennedy bill would be a major step forward for uninsured children and the fight against tobacco addiction. On behalf of Children's Hospital Boston, I offer you our support and our promise to work with you toward this goal.

ON a final note, I would like to extend the heartfelt gratitude of the Children's Hospital not only to Senators Hatch and Jeffords and to other Members of the Senate and House for taking a leadership role in this debate, but especially to Senator Kennedy for his continued commitment to our Nation's children and their health care needs. He has been a true friend to the children of Massachusetts, to Children's Hospital, and to all the teaching hospitals in Massachusetts. Senator, we thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you. I certainly echo those comments about my colleague. I know of the great work he has done.

[The prepared statement of Ms. Palfrey follows:]

PREPARED STATEMENT OF JUDITH S. PALFREY, M.D.

Mr. Chairman and members of the committee. Good morning. My name is Judith S. Palfrey, M.D. I am the Chief of the Division of General Pediatrics at Children's Hospital in Boston and the T. Berry Brazelton Professor of Pediatrics at the Harvard Medical School. I have been a practicing pediatrician at Children's for 20 years.

Children's Hospital in Boston is the largest pediatric medical center in the United States. Founded in 1869 as a 20-bed hospital for children, today it is a 300-bed comprehensive center for pediatric health care. Among pediatric hospitals, Children's has long been distinguished for its leadership in patient care and research, broad scope of services, commitment to training and legacy of accomplishment.

Children's Hospital is a complex and multi-faceted institution, yet its mission is quite simple: to take care of sick children. Each year, the hospital records nearly 16,000 inpatient admissions and approximately 250,000 visits to its more than 100 ambulatory programs and Emergency Services. Children's also conducts the world's largest and most comprehensive pediatric research program. And as an internationally renowned teaching hospital affiliated with Harvard Medical School, Children's attracts promising young physicians who seek the opportunity to learn from and work with professionals who are among the best in their fields.

I am a pediatrician. I don't pretend to understand politics, the intricacies of the Federal budget, or quite frankly, the complex legislative process. What I do understand are children and I know from personal experience about their health care needs.

As Dr. Eaton has shared with you, children are not simply small adults and they have very different health care needs than adults. And it is our responsibility as

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citizens to help meet those needs. Dr. Akhter has outlined for you some of the many public health challenges we face today in ensuring that our children are healthy. Each of those issues is vitally important. And interventions in each of these areas can have a huge impact on the health and lives of children. As Dr. Eaton noted, there is one overriding issue that can have a significant impact on every child's health status—that is making sure that every child has health insurance.

Carefully conducted studies by the GAO and researchers around the country have clearly documented the direct statistical correlation between children's insurance status, access to care, and good health. What I want to show you today with some examples are the direct costs of failing to provide insurance to children: the impacts on them, their families, the entire system of care and on our Nation as a community.

At Children's Hospital, my colleagues and I see the frightening results of the lack of insurance. We see parents delay preventive care visits, put off surgeries, even refuse to have x-rays when their children have had an accident. I have had parents apologize to me for missing vaccinations when they have been laid off from their jobs. This is a problem not only for the family. Children who are not immunized—for instance for whooping cough or rubella—present a threat to small infants, pregnant women, and the general public.

The costs of not insuring our children do not devolve to the families alone. Consider the consequences of missed routine preventive care. The child with asthma develops an attack at 8 p.m. With no medicine in the house, by 10 pm., the child is so tight, that the mother must call an ambulance. At the emergency room, the child receives the care that could easily have been administered at home if she had had a preventive visit. This scene is repeated over and over again for the 600,000 children who have asthma and no insurance.The costs of this scenario are enormous. Who pays? The child, the family, and, yes, the other insured patients who visit the hospital. They cross-subsidize this expensive, avoidable emergency care.

The parents I have mentioned all want the best for their children. But without jobs often they cannot afford premiums as high as 5,000 to 6,000 dollars a year. Until recently, some parents were denied insurance for an even more devastating reason—because their child had a pre-existing condition. And for many working parent, their employers don't offer health insurance.

This Congress and this Committee have made great strides in removing some of the serious barriers to health insurance for working families and their children, most notably in the Kassebaum-Kennedy legislation last year. All of us who care for children thank you for your support and commitment. However, we need to do more. We need to make sure that all children have access to quality health care.

In Massachusetts, we have recently passed legislation to increase children's access to health insurance. This expansion builds on the successes of the Medicaid program by making it available to all individuals, including children and families, up to 133 percent of the Federal poverty level. The legislation also gives the State the option to expand the program for children under age 13 up to 200 percent of the Federal poverty level. In addition, for those families who earn too much to qualify for Medicaid, a State-run insurance program called the Children's Medical Security Program has also been expanded for children under age 19 up to 400 percent of the Federal poverty level. This program is limited in its coverage, in large part, to primary and preventive care. Of the approximately 160,000 uninsured children in Massachusetts, almost 100 percent of these children will have access to some type of insurance coverage, albeit some of it limited, when the legislation is fully implemented. We will be joining with the state and the children's advocacy groups to implement a broad outreach initiative to encourage as many of these families as possible to participate.

What I think has made the Massachusetts approach interesting is how we pay for it. We raised the tax on a pack of cigarettes by 25 cents. Children's Hospital supported this approach wholeheartedly. We were, and continue to be, unapologetic about our support of this increase in the price of cigarettes. We think it is a very small price to pay for guaranteeing the health of our children. And, it has a secondary benefit. It would help stop children from beginning to smoke.

Some 3,000 children begin smoking every day. One third of them will eventually die of their addiction. We need to do all we can to prevent our children from taking up the habit. Studies have shown that children and youths are more price-sensitive than adults when it comes to buying cigarettes. When the price goes up, consumption of cigarettes among teens drops. This is a win-win situation.

Senators Kennedy and Hatch have adopted this strategy in their legislation to expand access for children. First, like the Massachusetts plan, this legislation seeks to insure more children. It retains the Medicaid program and builds on top of it, insuring more children while preserving the Medicaid safety net. The importance of this point cannot be overemphasized. Medicaid is the single largest insurer of chil-

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dren in the country and one of the most important child health programs we have seen to date. The full benefit package offered by Medicaid is crucial to the well-being of children, because it has been designed precisely to meet their unique needs, including medically necessary care. We need to retain this safety net at the same time that we look for innovative ways to expand access for those children who do not qualify for Medicaid.

And, like the Massachusetts plan, the Hatch/Kennedy bill pays for this expansion through a cigarette tax. We believe that an expansion of children's health insurance funded by a cigarette tax is a winning combination. enactment of the Hatch/Kennedy bill would be a major step forward for uninsured children and the fight against tobacco addiction.

I am well aware that there has been serious debate about how best to achieve improved access for children. I do believe, however, that each of you will agree with me that our mutual goal is to improve the health status of America's children and to Increase access to health insurance is one important step toward that goal. On behalf of Children's Hospital, I offer you our support and our promise to work with you to reach this goal. The future of nation's children is dependent upon our efforts.

On a final note, I would just like to extend the heartfelt gratitude of Children's Hospital not only to Senators Hatch and Jeffords and to other members of the Senate and the House who have joined us in this debate but also especially to Senator Kennedy for his continued commitment to our Nation's children and their health care needs. He has been a true friend to the children of Massachusetts and to Children's Hospital for years. And, I believe I speak on behalf of all of the teaching hospitals in Boston in thanking the Senator for his commitment to the teaching and research missions of our institutions. His support of our work in discovering new advances in fighting disease and in training the next generation of providers is appreciated today and will be felt in the decades to come. Senator, thank you.

Thank You for this opportunity to testify. I would be happy to answer any questions you might have.

The CHAIRMAN. Dr. Akhter, it is a pleasure to have you here. I know you share with me some similar concerns about the District of Columbia. I commend you for your work in this great city, which we aim to make greater.

I would like to ask you about the definition of "public health"; I think that sometimes we consider it to be only insurance and health care paid for by somebody else. Could you define the term "public health," so that we can bring our task into better focus?

Dr. AKHTER. Thank you, Mr. Chairman. I appreciate the question.

Public health is what society collectively does to protect the health of its people. It means the clean air, the clean water—these are things that individuals cannot do—but more important, it is somebody watching all the time the progression of disease and what is happening in the community. It is a monitoring function in the community and being prepared to move, whenever there is a case, to treat that case and prevent the disease from spreading to other people. And this is carried out at both the local and State level and at the Federal level. The local level is where it is practiced the best, where you work in conjunction with the community to monitor their health status, identify where the problem areas are and then try to provide solutions. That is really the main essence of public health.

What we do, for example, is to keep children from going to the doctor or to the hospital, because keeping people healthy results in less expense on the other end. We are the ones who initiate antismoking campaigns, we are the ones who do screening of children for various diseases, we are the ones who go out and screen for hypertension, cancer screening, because early diagnosis and early treatment is really the key. We are the ones who provide education to diabetics so they can stay healthy as far as possible.

So that essentially, what public health does is put life into those years, so the public will continue to be healthy. That is the role of public health.

The CHAIRMAN. What kind of coordination do you have with insurance companies, to ensure that the government and the insurance industry complement each other?

Dr. AKHTER. We have had areas of overlap in the past. The way the system has evolved over the years is that the community-based services became the responsibility of the local or State government, and individual care became the responsibility of the insurance; but there are areas that overlap, for example, education—how do you provide information to people about how to stay healthy—exercise, eat a good diet, do not smoke—that area, of course, we share. Screening of individuals so that we can identify early on is an area that we share with the insurance companies.

More recently, though, as we have moved into managed care, as we have done in the District of Columbia, we have made sure that a package of preventive services like EPSDT, early diagnosis, treatment and prevention, becomes part of the managed care entity, so that we require them to do some of these functions. So these two things are now becoming more and more linked, but that does not mean we do not need to have the overall system monitoring and quick action in place, just like the fire department. You need to have a system in place so that if something happens, you can go in and take action.

The CHAIRMAN. Dr. Eaton and Dr. Palfrey, could you describe for me the specific health care needs of children in the age categories birth to age 6, 6 to 12, and 13 to 18—do these groups have different needs, and how do we focus attention on each group?

Dr. Eaton.

Dr. EATON. Thank you, Mr. Chairman. I think the best response to that question would be to say that the needs of those different age groups are certainly going to change based on the developmental stages that the young infant or young child may be going through versus the school-age child and the adolescent.

It really illustrates I think very nicely why, when we talk about the types of benefits that children need, that they do need a comprehensive set of benefits and that the academy of pediatrics and the National Association of Children Hospitals have really been instrumental in seeing that that set of benefits is outlined. And it is certainly not going to be just medical benefits. I think that when you talk, for example, about adolescents, many of the benefits that they may need would come under the category of psychosocial needs. So it is really going to be a package of benefits that is going to vary with the age of the individual, with the developmental stage of the individual, whether they have any intercurrent acute or particularly chronic illnesses, and the benefit package that has been designed very much tailors the kinds of services that a child or an adolescent may need based on the developmental stage.

The CHAIRMAN. Dr. Palfrey.

Dr. PALFREY. Senator Jeffords, we are going to give you a child development award. Your question includes in it the understanding of these different, progressive times for children, and it is so important, because in the zero to 6 period of time, we are talking about

growth—the child actually triples his weight during that period of time, the brain develops, and all of these things occur. They need to be nurtured with preventive immunization care, and their nutrition needs to be looked at in a particular way.

The next group of kids is becoming much more independent and also becoming much more likely to have injuries, so we need to tailor what we do during that time to grabbing hold of the injury prevention—helmets for bicycle riding, and so forth.

And then, in the adolescent period, these are young adults, and they need to be taking on their own health care and looking at things like not smoking or teen pregnancy.

So that in pediatrics, we have got to tailor what we do using the EPSDT and now, increasingly, the Bright Futures guidelines, to have all of that available for children each time they come either to the physician, or those things need to be available, as I mentioned before, in everybody's situation—child care, schools, and even businesses need to be helping us with those three periods of time.

The CHAIRMAN. Thank you. I raise that issue because we are going to address the question of child care and what Government-sponsored services ought to be offered. In Federal programs, for instance, there are no standards right now for child care. I know standards vary from State to State, and I am sure that Senator Kennedy and Senator Dodd in particular, as well as Members on my side, are going to rely upon you to help us design Federal standards.

Dr. EATON. If I may, Mr. Chairman, there is also a very major initiative that the American Academy of Pediatrics has undertaken, which Secretary Shalala made reference to, and that is the Healthy Child Care American campaign. In addition to that, the Academy of Pediatrics has actually worked with the American Public Health Association and produced a wonderful document that actually outlines the health and safety needs for children in child care.

So I think that a lot of work has been done, and I think a strong foundation has already been built, and we would certainly welcome the opportunity to work with you further on that.

On a personal level as the mother of four children and the grandmother of seven, I will say that I have had to live with the issue of identifying quality child care, and I feel very, very strongly that this is an important initiative for all children in this country. So we would be delighted to work with you.

The CHAIRMAN. Thank you.

Senator Kennedy.

Senator KENNEDY. Thank you very much, Mr. Chairman.

Just to come back, Dr. Eaton and Dr. Palfrey, to your comments to Senator Jeffords—and thank you, Dr. Palfrey for your other comments; I am grateful to you for those. Some have suggested that we have programs that would tailor health care coverage for the different ages rather than doing a more comprehensive kind of program. What is your reaction to this suggestion?

Dr. EATON. I guess I can have a very immediate reaction to say that a very important principle that we uphold—that is, the two organizations that I am representing, the Academy of Pediatrics and

the National Association of Children's Hospitals—is that we want a comprehensive program that is really going to address the needs of the infant at birth through age 21, because we feel that that is the only approach that is really going to be acceptable to respond to the significant problem that we have with both uninsured and underinsured in this country.

Senator KENNEDY. Dr. Palfrey.

Dr. PALFREY. I would agree with that.

Senator KENNEDY. As you know, in our program, we basically have the Medicaid benefit package—a number of the States have lesser packages, as we in Massachusetts do, and we are going to try to address those gaps with this legislation. But most of the other States, some 31 States, have varying kinds of programs dealing with children and their health.

So I gather that you know the benefit package that is included in that Medicaid package; do you have a reaction as to whether you think that that is generally the type of comprehensive package that we ought to stay with?

Dr. EATON. Again, I can make my answer to that question unequivocal. We feel that the EPSDT benefit package is certainly a very comprehensive benefit package, is very much based on the standards that have been developed by the organizations that I am representing, and we would applaud, I would say strongly, the inclusion of that in the legislation.

Senator KENNEDY. Good.

Dr. Palfrey.

Dr. PALFREY. Absolutely. EPSDT obviously stands for early periodic screening, diagnosis and treatment, and one of the things that we would want to underscore is the fact that it does not make any sense to screen for lead poisoning if you are not then going to treat it. So that is an extremely important thing.

The other thing that the Medicaid benefit package does is that it is very sensitive to the needs of children with special health care needs. It is a program which provides the case management, the OT, the PT,the home visiting by nurses, and so forth—and I know, Senator Kennedy, that you know very well the needs of children with severe health care problems. This is a very small group of children, but they are the ones that we as a nation must provide the care for. So that Medicaid—it is interesting the people said it has a stigma, etc; those of us in pediatrics for a while felt that way—but it is the best benefit package that we have for children, so it is coming around now as being more than—it is not a safety net, it is the best that we have.

Senator KENNEDY. And children deserve the best. I think it is important that we get this kind of testimony because there will be those later on as we go through this process who ask what are we going to cut out, what are we going to cut back on, what are we going to reduce, and do we need this range of services. I think your testimony underlining the importance of this is very important.

Let me ask you sort of an attitudinal question. There are critics of our program who say that this is really more of a parenting problem than it is of children who are uninsured—the parents are going to baseball games or buying expensive sneakers or buying another stereo or whatever it is—and if we could get these parents

to be more responsible, we would not have to burden the tobacco users or others to try to get a health care package for our kids.

What kind of reaction do you have to that?

Dr. PALFREY. Senator Kennedy, some of these families cannot buy enough food for their table. I was just doing a calculation. For a family of four at, let us say, 150 percent of poverty, earning $30,000, that is $25,000, and then you have to pay $5,000 for insurance? I would like to see anybody here live on that amount of money. I do not know how people get transportation. This is a direct need for money for these families. They are not out there, buying extra things with it.

Dr. EATON. I would certainly strongly support the response that Dr. Palfrey has just given. I would also say that in my almost four decades of being a pediatrician, I have dealt with a lot of families, and I have actually spent most of my time working with low-income families and with children with special health care needs, and I can attest to the fact that that parent that is being described who, let us say, is being irresponsible or neglectful of his or her child is certainly very minimal in my experience.

The vast majority of parents with whom I have worked want, just as you and I want for our children and our grandchildren, the best. They want them to have access to health insurance.

So I would say that I could quickly refute that notion.

Senator KENNEDY. Dr. Akhter.

Dr. AKHTER. Senator, you are absolutely right. These are the people who are really trying to do the very best for their children. They just do not have the resources to put into this effort. That is the bottom line.

Senator KENNEDY. Dr. Palfrey, before the light turns red, let me just ask if you might outline very, very briefly—we will hopefully have a chance to discuss it to a greater extent at another time—the lessons that Massachusetts has learned by moving ahead with this program which has gone into effect and was really an inspiration to me and I know to my colleague, Senator Kerry, and to others who watched it closely.

Dr. PALFREY. I think there are several aspects that are important. First of all, this program does cover children under 12 up to 200 percent of poverty under Medicaid now and then expands the Children's Medical Security Program, which is very much like what we are talking about here.

I think one of the biggest lessons that we learned was that there was a groundswell of support for this program, and it came from everywhere, including the elderly. The AARP was a very strong supporter of this, and it was not something that was particularly difficult to get through, as you know; it had to go over a gubernatorial veto, and they were able to garner support for that. So there was tremendous support for it.

Senator KENNEDY. Thank you very much. As you probably know, I have had two children who have benefited from Children's Hospital in Boston. One of them, Patrick, is a chronic asthmatic, and Children's Hospital had the only approval, regionally, to use some experimental modalities which were just instrumental in his recovery.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Dodd.

Senator DODD. Thank you very much, Mr. Chairman, and I appreciate your being here. Let me begin by just briefly saying to all three of you that I have often said we would not have done anything, and we would not have been successful on the child care legislation, on the family and medical leave legislation, had it not been for the American Academy of Pediatrics. I am your biggest cheerleader.

Dr. EATON. Thank you.

Senator DODD. It is a terrific group of physicians, and it has been marvelous to see the impact you have been able to have on national policy with regard to children over the last number of years, and we want you to keep it up, and I am confident you will, having listened to you here this morning.

I have just a couple of points. One, let me underscore the point you have made about the elderly, Dr. Eaton. Like all of us back home on weekends or recess periods when we are not in session here in Washington, we visit our senior citizen centers around our State, and in Connecticut, I find that most people assume that that audience is anxious to hear you talk about Social Security and Medicare and pensions and so forth. If you want to get the best reaction and response from an elderly audience, talk about children. The best response I ever get is when I go in and talk about children—their grandchildren, their great-grandchildren—and what is happening with kids in the country. They have more ideas and more thoughts and show more interest. So I think it is one of the great fallacies that people assume that this is a generational conflict. In fact, it need not be a generational conflict if you listen to the elderly in this country. And the point made by Governor Dean, where we provide health care for people over the age of 65 regardless of income—I think the strongest point we will find for universal coverage for children in this country will come from those over 65. I am very confident of it.

In Connecticut, we are very proud of our Children's Hospital. We have a new one, and we think it is the State of the art in the country. It just opened its doors a few months ago. I went up recently to visit again and in fact held a hearing up there on children's health at Children's Hospital which was very worthwhile.

We heard Governor Dean say earlier how inexpensive it is to take care of children, and I think that that is a good point because you are dealing, as you have pointed out, with acute rather than chronic problems, generally. There are about 3,000 hospitals in the country if my memory serves me correctly. I think we have about 60 children's hospitals in the country; is that right?

Dr. EATON. Well, the members of the National Association of Children's Hospitals number about 100, but they are different; some are specialty hospitals, and some may be pediatric units in a general hospital. So that is probably a clear reflection.

Senator DODD. OK. What I want to get at here is that it is expensive to take care of kids in a hospital, and I want you to talk about that, because I think we might have left people with some misimpressions here. What I am getting at is this. As I went through the emergency room of Children's Hospital, what you run into all the time with these poor families is they do what other peo-

ple do—they wait, and they wait, and they wait, and they wait, hoping beyond hope that this problem will go away, that that little sore will not get infected, or if it gets infected that the traditional cure-alls might take care of it—and of course, it reaches a crisis, and that is when they show up, and instead of having a modest problem that could have been dealt with, you get into the chronic problem or the acute problem that requires hospitalization or serious mediation.

The waiting rooms are filled with kids like this. In fact, the primary care physician in Hartford is the waiting room of the Children's Hospital. I want you to comment about that relationship—you have already talked about it—but in terms of the cost, because when you buy equipment for a children's hospital, given the few that exist, the unit costs are just different, and I do not think a lot of people are familiar with the fact that it is costly to take care of a child when hospitalization is required.

I wonder if you might comment on that.

Dr. EATON. I would be happy to respond, and I guess Dr. Palfrey, being at Boston Children's Hospital, would probably like to add her views on this as well. You are right in saying that children's hospitals do in many instances take care of the most complex problems of children in terms of either illness or injury, and by virtue of the fact that they are taking care of the sickest and most acutely ill patients, that is going to generation higher costs. In addition to that, because children cannot provide any of their care themselves as an adult hospital might, the kinds of resources that are necessary to provide care for children are going to be more costly. For example, they are going to require more nursing care, more respiratory therapy. There is just a whole host of other resources that are required in that children's hospital.

Let me address the issue of the emergency room. And certainly, I had the administrative responsibility for the emergency room at Children's Hospital in Columbus for 10 years, and I know exactly what you are talking about—but let me assure you that there are major efforts taking place at children's hospitals to really get the patient who uses the emergency room inappropriately, that is, when they do not have another source of health care to use it for their primary care, we are making every effort, monumental efforts, to shift that care to a primary care physician or to a primary care site. We actually have established seven community health centers as part of the Children's Hospital system in Columbus, OH, so we are very much addressing that.

The final comment I would make is that what you have identified here in terms of the use or overuse of emergency services clearly highlights the need for us to develop a system which guarantees access to care at the primary and preventive level while maintaining the very strong system of care that we need for that child who is acutely ill or chronically ill or injured and have a strong system of pediatric subspecialty services from both the medical and the surgical point of view.

Senator DODD. Dr. Palfrey.

Dr. PALFREY. I had told a little story, maybe while you were out of the room, about a child coming in with asthma, a very common story, to a pediatric emergency room. The preventive care that

could have been given to that child is the provision of a little nebulizer which can be kept at home. We are finding that these little nebulizers are keeping children out of the hospital, out of emergency rooms and back on the playground. We can even use these little nebulizers in schools. I saw a program in Kentucky which calls the school health room "the nebulizer Ninjas." The children come down, and they take their little puff of medication during the day, they achieve their own personal best in terms of being able to breathe, and those kids have cut down emergency room use and hospital room use.

What we are talking about is shifting the focus of care to prevention, and that will save enormous amounts of money. Having done that, we will then have that money available when a child has cancer, when a child has a cardiac anomaly that needs to be fixed. And yes, it is expensive to have micro surgery; it costs a lot of money. It costs a tremendous amount of money to provide safe Factor 8 to children who have hemophilia. In order to protect the blood supply, it costs money—but that is what we should be able to do in the United States of America.

Senator DODD. I do not disagree, but what I want to point out here—and by the way, Governor Dean was not suggesting this; his point was that because children do not have as many chronic illnesses,they recovery quickly and so forth, that you can insure children a lot less expensively—but I do not want people to be left with the impression that it is less expensive to care for a child if you do not provide insurance. It is a lot more costly, and that is the point you are making, and I think we need to drive this home. And Mr. Chairman, maybe through our witnesses here doing a little more work for us, we could get a comparative cost analysis of a child who requires hospitalization versus an adult for an equal period of time, so we can give people who are not moved by the ethics and the morality of this some idea that the cost factor, preventive care, given the cost of having to provide that kind of care for a child if they do not get it, is so much higher, and that might really help persuade some people—not that the chairman or anyone else needs persuading, but others who are doubting Thomases here might need some persuading—that this is really very smart economics. That is my point. It is very smart economics.

Dr. EATON. Certainly the National Association of Children's Hospitals and the American Academy of Pediatrics would be very happy to provide whatever data you think might be helpful.

Senator DODD. That would be helpful.

The CHAIRMAN. We appreciate that very much.

Senator DODD. I just want to commend Dr. Eaton as well. We should take a closer look at the child care standards that you helped develop for the public health services. Again, I commend you for that, and I gather you made some comments here, and I appreciate that immensely. I thank you for the tremendous help that the American Academy of Pediatrics has been to us in our development of child care policy.

Dr. EATON. Well, we would certainly be most willing and eager, I might add, to work with you on this issue and certainly on the child care issue. A lot of work has already been done with respect to the child care standards that we could provide.

Just one more thing I would have to say, Mr. Chairman. I would be remiss as a pediatrician from Ohio—and since you made reference to Senator DeWine in your introductory comments—if I did not say that we have worked very closely, and I have had the personal privilege of working with Senator DeWine and his staff around a number of child care issues, particularly the issue of pediatric research, a and I do want to say how fortunate we are to have that kind of a relationship and have him representing us in this Congress.

The CHAIRMAN. Well, we enjoy having him on the committee, and I will pass those words along.

Dr. EATON. Thank you.

Senator DODD. Mr. Chairman, I wonder if there is anyone in the audience from Connecticut—we have Massachusetts and Ohio represented; I feel kind of lonely up here. [Laughter.]

The CHAIRMAN. Let me follow up a little bit. There are other issues besides coverage. Other relevant factors for instance, might be a community's culture and language; an area's geography; the availability of transportation. I would like you to comment briefly on these additional factors, which can affect coverage. How shall we handle these issues?

Dr. EATON. I guess I will first respond by saying the question as I anticipate is that if we had health insurance coverage, we would address the financial barriers to care; that would help eliminate the financial barriers to care. But there is a whole host of nonfinancial barriers to care which you have identified. Certainly, transportation would be a very important one; it may be culture or language problems, and there are many other aspects of access that are important to address. I think that that is something where we can work with not only the private sector, with which I have been most involved, but also with the public health sector, to see that we do reduce or, ideally, eliminate the nonfinancial barriers to access to care.

The CHAIRMAN. I think it is important that we focus attention on those barriers; because a person can have coverage, but without the ability to verbalize his health problems to a professional or to arrive at the site where health care is administered, then his coverage, obviously, is not very useful.

Dr. Akhter.

Dr. AKHTER. Senator, the access is a really fundamental issue. Even if you have the coverage, if there is nobody to provide the service, you might end up like having good fire insurance, but no fire hydrant. In inner cities and rural areas, access is a key problem, and I think that that is where you need to work, with the States and with the local communities, to really make that arrangement. I would not want to complicate the situation very much at this stage. Let us focus on providing health coverage to children, but make an attempt in the legislation to have some provisions where the access issues at the local level are addressed in conjunction with the States and local jurisdictions. And we would be very glad to work with you and the members of your staff to really provide input and support in that regard.

The CHAIRMAN. I appreciate that. I do have additional questions for you, but we have another panel, and we are going to run out

of time if I do not move along. So thank you very much. We will be back in touch and have more questions for you, I assure you.

Dr. EATON. Thank you for your leadership.

Dr. PALFREY. Thank you, Mr. Chairman.

Dr. AKHTER. Thank you.

The CHAIRMAN. I will how call the final panel forward. Mr. James Copple is president and CEO of Community Anti-Drug Coalitions of America. His extensive background in community organizing and education fits well with his current task of promoting and facilitating local and comprehensive responses to our Nation's drug problems.

Thank you for being here.

Dr. Mary Jane England is president of the Washington Business Group on Health, a policy and research organization whose membership includes the Nation's major employers. She has previously served as president of the American Psychiatric Association. Dr. England is a specialist in child psychiatry.

Welcome to you both. Mr. Copple, would you please proceed?

STATEMENTS OF JAMES E. COPPLE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, COMMUNITY ANTI-DRUG COALITIONS OF AMERICA, ALEXANDRIA, VA; AND DR. MARY JANE ENGLAND, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH, WASHINGTON, DC

Mr. COPPLE. Thank you, Mr. Chairman. it is a privilege for me to be here with you today to represent the 4,300 community anti-drug coalitions that we represent in every State and three Territories.

This is an important issue; the issue of child care and child health is important to the mission of our members related to substance abuse, drugs, alcohol and tobacco, and it is important for us to be represented here and to raise our voice in support of a number of the issues that have already been addressed.

I would like to put in context my remarks by relating a story about when I was leaving a local coalition in Wichita, KS called Project Freedom. I was assistant superintendent of schools, and we were hearing anecdotally that we were having a major problem with drug-affected babies in our community. Our coalition put together an initiative which sponsored a study of 800 live births over a 3-month period, and out of that, we discovered that 18 percent of our live births were drug-exposed. It cost in Wichita, KS at that time, 4½ years ago, $3,700 to give birth to a normal-weight child. Before a drug-exposed baby left the hospital in our community, it cost approximately $150,000. That does not take into consideration the costs once they arrived in kindergarten with related behavioral disorders or learning disabilities and other kinds of complications related to being low birthweight.

Those numbers translate into 144 children. The math on that is very simple in terms of those who were exposed: It cost our community $21 million in public and private health care costs to deal with that particular issue.

Quite frankly, with some help from then Senator Dole and Congressman Dan Glickman, we were able to put together a program

that cut that number in half and saved our community significant resources.

That success, however, must be understood in the context of 5 years of increased drug abuse that we have seen in this country. According to the Partnership for a Drug-Free America's 1996 attitudinal tracking study, one in four children, 24 percent, 9 to 12 years old in 1996, compared with 19 percent of the same age group in 1993, were offered drugs during the 1996 calendar year. I often compare this with my own two children. I have a 21-year-old who, when she was in 8th grade, was never offered drugs. She never saw anybody being offered drugs; it was not an issue or a problem with her. My second child, a 14-year-old, who last year was in 8th grade, was offered drugs six times and attended the funeral of one of her classmates who overdosed on cocaine at the age of 14.

The landscape has changed significantly with these increased numbers. Trial use of marijuana increased among children from approximately 230,000 children in 1995 to 460,000 in 1996, from 2 to 4 percent of the total child population between 1995 and 1996. Because of these increases, we can anticipate increased exposure to long-term addiction, greater accidental deaths as a result of driving cars while under the influence, increased family abuse and a greater threat from diseases associated with sustained use of illegal and legal drugs.

The committee asked me to summarize the issue in terms of the nature of the problem, and I have given you statistics that illustrate the 5 years of growth, but to also respond to what the Federal Government can do and also the private sector. I would like to speak specifically to what the Federal role could possibly be on this issue to assist us, because this is very critical to what we are about.

The National Center on Addiction and Substance Abuse at Columbia University has demonstrated that if we can prevent children from using drugs before the age of 19, we are winning the battle against alcohol, tobacco and other drugs. But to do this, all programs across the continuum of care for children and adolescents must be authorized and funded. Local communities cannot adequately address this new wave of increased use if we do not have a national infrastructure to support our efforts. SAMHSA reauthorization is vital to our efforts, and adequate funding support for prevention and treatment must be sustained.

We have been working closely with the Senate and the House in trying to pass S. 536, the Drug-Free Communities Act, which would put more resources directly into community hands, working with our States, to deal with this problem in both prevention and treatment.

We need to continue to support good research that moves from research to practice. We cannot afford to simply have research for research's sake; we have got to be guided by good science and good practice in this field, and we urge Congress to continue to support those kinds of efforts at the National Institute on Drug Abuse and also the National Center for the Advancement of Prevention. That is critical to our success and our future.

The private sector also has a major role in this. I often compare what we do in local communities with what goes on at any given

football game: We have 22 people out on the field who need rest being watched by 22,000 people who need exercise. [Laughter.] From our perspective, it is time that we engage the whole community—the media, the faith community, the schools, every sector—to make this happen. S. 536 will help facilitate and promote that initiative to be sure that we have an inclusive, comprehensive strategy to deal with this issue.

Every $34 million we spend in treatment in this country, we work against $246 million in law enforcement. Every $34 million we spend in treatment, we save $246 million in law enforcement and, according to a Rand study, every $1 for treatment, we can stop spending $7 on the law enforcement end of the spectrum. That kind of analysis is supported by such organizations as the International Association of Chiefs of Police. We need to do more on the prevention and treatment side for children; 1.7 million teenagers in this country need and want treatment but cannot access it or cannot afford it. In an increased climate where we see drug abuse on the increase, we have got to respond with a national infrastructure that will make those changes and do the right kinds of things for these children.

Our organization stands ready to work with the committee in any way we possibly can to support you and your efforts to see that this issue is addressed among America's children.

Thank you.

The CHAIRMAN. Thank you very much, Mr. Copple.

[The prepared statement of Mr. Copple follows:]

PREPARED STATEMENT OF JAMES E. COPPLE

Chairman Jeffords, and distinguished members of the Senate Committee on Labor and Human Resources, it is an honor for me to appear before you today to speak on behalf of CADCA's 4300 community-based coalitions. Our members are engaged in their local communities to reduce and prevent substance abuse among all citizens, but particularly among young people. Improving the health status of children is the primary mission of our members and addressing the complicated and difficult issues around child and adolescent substance abuse is critical to the success of that mission.

I would like to begin my remarks by providing a real life picture of what we are facing in local communities around drug abuse and its subsequent impact on children. In one community where I served as Special Assistant to the Superintendent of Schools, Wichita, Kansas, (POPULATION 425,000) the local substance abuse coalition I directed conducted a blind study of 800 live births over a three month period in 1992 to assess drug exposure of infants. The results were alarming. Eighteen percent of all live births showed positive signs of cocaine in the infant at the time of birth. That 18 percent translated into 144 infants who were drug exposed at the time of their birth. In Sedgwick County, Kansas, in 1992, it cost approximately $3,700 to give birth to a normal weight child. When a child is drug exposed, they are usually premature and experience a number of medical problems that require them to stay hospitalized for longer periods of time. The average hospital costs of a drug exposed baby in Sedgwick County was $150,000 before the child left the hospital. These costs are generally assumed by the public by way of increased costs in insurance and in welfare assistance for those who cannot afford insurance. Just in hospital costs alone, the 144 drug exposed babies in the three month blind study cost Sedgwick County, Kansas approximately $21 million. Those costs do not take into consideration the delayed costs of responding to children who possess the risk of attention deficit disorders, behavioral disorders, or learning disabilities as a result of their exposure to drugs. These 144 children will enter kindergarten in the fall of 1997. All of this in conservative Sedgwick County, Kansas. With assistance from former Senator Robert Dole and former Congressman Dan Glickman, we were able to acquire $100,000 annually to assist the community in their efforts to reduce this number.

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The above data points to one community. It was a community that implemented an intervention strategy through collaboration and coordination by its local coalition, Project Freedom, and the coalition actually reduced those numbers by half. With assistance from OB/GYNs and family doctors, information about the dangers of substance abuse during pregnancy was placed in the hands of every prospective mom. Neighborhood caseworkers were assigned to neighborhoods with high incidences of crack babies and eventually the program began to have impact. That success must be understood, however in the context of five years of increased drug abuse among America's youth. According to the Partnership for a Drug-Free America's 1996 Attitudinal Tracking Study, one in four children (24 percent of 9-12 year olds in 1996; compared with 19 percent of the same age group in 1993) were offered drugs during the 1996 calendar year. Trial use of marijuana increased among children from approximately 230,000 children in 1995 to 460,000 in 1996 (from 2 to 4 percent of the total child population between 1995 and 1996). Perception of harm and risk have decreased while use has increased. Eleven to 12 year olds who report they have friends who sometimes use marijuana, increased from 7 percent in 1993 to 13 percent in 1996. News from communities regarding the dangers and consequences of illicit drug use is anything but good. Because of these increases we can anticipate increased exposure to long-term addiction, greater accidental deaths as a result of driving cars while under the influence, increased family abuse and a greater threat from diseases associated with sustained use of illegal and legal drugs.

If use patterns continue to increase at these alarming rates, and as adolescents enter the work force, marry and have their own families, then a new generation of young people will be made vulnerable to substance abuse among parents and peers. Already, 71 percent of the current addicted community are in the workforce. That is good news and bad news. The good news is that businesses, particularly the large Fortune 500 companies have adopted drug-free workplace programs that include access to treatment. The bad news is that medium- and small-businesses have yet to see the financial incentive of adopting drug-free workplace programs. These companies experience higher absenteeism, theft, increased health costs as a result of illnesses and diseases associated with addiction, and the threat of legal action when employees perform poorly while under the influence of drugs. The problems of drug abuse continue to plague our society and cost us billions of dollars in wasted productivity and health care costs.

The committee has asked me to address three questions. The questions move to the heart of my testimony and offer both analysis and program suggestions for addressing this issue. The remainder of my testimony will focus on those three questions.

1. What are the substance abuse problems of children that we should work to prevent?

We must do everything we can to prevent first use or on-set of use of alcohol, tobacco, illicit drugs, and all forms of inhalants by children and adolescents. The National Center on Addiction and Substance Abuse at Columbia University has statistically demonstrated that if we can keep young people off drugs until the age of 19, then we have won the struggle. If there is no use by 19, then there is very little likelihood that they will ever use. Prevention and immediate treatment must be the cornerstone to federal, state, and community efforts to address substance abuse among youth. All programs across the continuum of care for children/adolescents must be authorized and funded. Local communities cannot adequately address this new wave of increased use if we do not have a national infrastructure to support our efforts. SAMHSA reauthorization is vital to our efforts and adequate funding support for prevention and treatment must be sustained. Brandeis University, through a research initiative funded by the Robert Wood Johnson Foundation, has estimated that there are 1.7 million teenagers who need treatment but cannot access it or afford it. To illustrate the growing severity of our problems, for the first time, in 1996 there were more kids presented for treatment because of marijuana than because of alcohol. Young people are becoming increasingly exposed to more illicit and dangerous drugs. The transition from marijuana use to the use of other illicit and dangerous drugs is not a difficult transition. In fact, CASA (Center on Addiction and Substance Abuse), at Columbia University, has found that a youth who uses marijuana before age 12 is 42 times likelier to use drugs like cocaine and heroin. As we examine the issue of insurance coverage for America's children, it will be critical to examine the scope of insurance coverage and its relationship to drug and alcohol treatment for young people. Our ability to provide treatment for addiction will impact what we cover related to its subsequent diseases.

To summarize this point, the prospect of more and more children presenting themselves for treatment, also forewarns us of an increase in crime and educational literacy problems. More and more children will find themselves incapable of per-

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forming in school, will become frustrated entering into adolescence and, as a consequence, be at-risk for dropping out and finding illegal alternatives to acquire resources to support their habit. The use of alcohol, tobacco and other illicit drugs for youth will have a pervasive impact on our society. The educational, criminal and societal impact will force us to spend money at the end of the spectrum, and could possibly require us to build even more prisons. We must work to prevent this and dedicate both will and resources to stem this tide.

2. How can we better address children's risk of substance abuse through improvements in federally-funded public health programs?

There must be an emphasis on comprehensive and inclusive community-based programs. The coalition model of collaboration and coordination is proving to be effective. The federal government can design its grants and programs in a way that compels federal, state and local entities to collaborate and coordinate. Such strategies eliminate duplication of effort and are better positioned to identify program gaps. Recently, while visiting one coalition member in Nebraska, it was discovered they had 23 separate funding streams addressing their community's substance abuse problem. Until the introduction of the Omaha Community Partnership, there had been little or no effort to coordinate or collaborate around a comprehensive and coordinated strategy.

The Federal Government has an opportunity to guide states and communities in the design and implementation of programs that are based on good science and practice. Thanks to the work of the National Institute for Drug Abuse (NIDA) and the National Center for the Advancement of Prevention (NCAP), good science and program research is being distributed to local communities. Today, more than ever, we are better prepared to implement programs that work and to guide communities to efforts that have a science and research base. We do not have to waste time or money on strategies that do not work. The federal government needs to continue to find ways to support these research centers. Research belongs in NIDA, NIAAA and NCAP. SAMHSA should continue to support program development and community practice that will prevent and treat drug abuse. It is imperative that communities be provided good research and the Federal Government should partner with states and communities in the implementation of tested strategies. To show the impact of community based efforts that are driven by research, I have provided four examples of community-based coalitions that have implemented programs based on good research and evaluation.

Little Rock, Arkansas: A partnership between the City of Little Rock and a city-wide coalition has led to the implementation of a comprehensive program which has been so well received that Little Rock voters have chosen to institutionalize these pilot programs with an additional 1/2 cent sales tax to support and expand them. Innovative programs include the establishment of neighborhood centers with action teams that include community police, code enforcement and neighborhood residents who have reduced the victim crime rate by 37 percent in the eight target areas and a special treatment program for pregnant women which has reduced the rate of alcohol use by mothers at time of birth from 37 percent to only four percent and has reduced the incidence of pre-term labor from 50 percent down to only eight percent.

Gallup, New Mexico: As the principal business center serving the Navajo Nation, Gallup had become infamous for having a high incidence of fatal car accidents and exposure deaths. This has been particularly problematic of the Native American population. As a result of the Fighting Back Coalition's efforts to establish responsible alcohol retail policies, Sunday Blue Laws, and a centralized detox and referral system, six of the seven most frequent causes of death have reversed their trend dramatically. In 1975, the suicide rate was 50 percent above the state average, and has dropped to be 40 percent below the state average in 1994. Similarly, the rate of drug-induced deaths in the county has dropped by 50 percent in the past 20 years, when at the same time the state average has increased by 70 percent.

Miami, Florida: The Miami Coalition created an intensive and targeted media campaign and drug awareness initiative which integrated the resources from the schools and community into one strategy. Businesses, law enforcement, local media and parent/teacher organizations worked together on message development and outreach to reach the youth populations targeted. In Miami, the reported drug use decreased by 55 percent during the campaign (from 5.4 percent in 1991 to 2.4 percent in 1993).

Hattiesburg, Mississippi: Project DREAM in Hattiesburg, Mississippi, implemented a strategy which included a school-based program for recovering teens, youth-focused substance abuse education in subsidized housing, and quarterly prevention seminars for new businesses. The outcome of these targeted efforts was that DUI arrests decreased by 28 percent, and arrests for individuals under 21 years de-

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creased by 45 percent. Additionally, the rate of DUI related injuries decreased by 42 percent.

Wichita, Kansas: Project Freedom of Wichita, Kansas implemented a comprehensive community-based substance abuse initiative that reduced single day-time and night-time vehicular accidental deaths attributed to illicit drugs and alcohol by 100 percent over a two year period. During the same period, programs established and funded by Project Freedom reduced DUI related arrests by 35 percent, juvenile drug-related crime following curfew by 65 percent and the birth of drug-exposed babies went down by 40 percent. Over the past four years, the rate of substance abuse increases among youth has remained well below the national average.

To summarize, the federal government needs to support community-based strategies that are evaluated and have outcome measures to demonstrate effectiveness. These strategies need to be comprehensive and planned across multiple community sectors, i.e., business, law enforcement, schools, medicine, faith, media, and the criminal justice system. Senate Bill 536, the Drug Free Communities Act, requires comprehensive planning based on outcome measures. Senate Bill 536, with major bipartisan support, is built on private-public partnerships truly creating an inclusive approach to address substance abuse among our nation's youth. Further, the Federal Government needs to create federal incentives to encourage the states to use the 20 percent set aside in the Substance Abuse Prevention and Treatment Block Grant to support this type of community planning effort and to fill the service gaps identified by communities. Coordination among federal, state and community initiatives is imperative to smart planning and program effectiveness.

3. How might we encourage the private sector to participate in partnerships with government and community organizations to address prevention of substance abuse in children?

I have often compared community-based efforts to reduce substance abuse and violence in communities to what goes on at any given football game. You have 22 people on the field who need rest being watched by 22,000 people who need exercise. Because of the pervasive problems associated with substance abuse, it is imperative that all sectors of the community become engaged in this effort. They must get into the "game." Civic clubs, workplaces, schools, the faith community, and media must be given opportunity to participate in planning and implementation of community-based programs. The coalition model affords this opportunity. Citizen participation in this effort is vital to our success. Parents, civic leaders and youth must come together to seek their community solutions. This problem, while resources are desperately needed, is best addressed when citizens create the "will" to address their problems. Resources follow community will. In this country, we generally solve the problems we truly want to solve. Children's health issues require adult advocates. When those health issues are addressed, then the whole community should celebrate. We must create the will to address this problem.

The Office of National Drug Control Policy (ONDCP) has suggested a national media campaign of $175 million to be matched by private contributions from the media industry. We support this effort. This effort should raise consciousness and will, and, based upon the work of groups like the Partnership for a Drug-Free America, has proven to be effective. Yet, I must say, when McDonalds put $85 million into the announcement of their Arch Deluxe Hamburger and Microsoft spent $125 million to announce their new Windows program, they knew they had stores in communities throughout America that could support the demand created by the advertisements. We must be prepared to do the same. As we raise awareness and demand for services, through the creation of public and private partnerships supported by federal, state and local resources, we must be sure we can deliver on our promise.

Often because of the stigma associated with adult abuse and addiction, substance abuse among children is viewed as bad decision making and avoidable behavior. Most of us working in the prevention and treatment arena have embraced the axiom that drug abuse is a preventable behavior and a treatable disease. Crime and drug abuse remain the number one and two concerns of the American people. Those concerns demand a comprehensive and inclusive response that is championed by the federal government, embraced by the states and implemented in local communities. We must fight through the stigma and support efforts to prevent and treat drug abuse among our nation's children. Failure to do so, will lead to greater crime and addiction among a new generation of youth. As a people we will pay more dollars in prison construction. Health care costs will soar as we will be required to treat the many diseases associated with substance abuse. Again, smart money is spent on prevention, early intervention and treatment. The Rand Corporation found that $34 million spent on treatment reduces cocaine use by as much as $246 million spent on domestic law enforcement. In effect, every $1 spent on treatment is worth $7 spent on law enforcement.

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On be half of CADCA's 4300 coalitions working in communities throughout the country, I want to thank you for the opportunity to speak on this very important issue. We look forward to working with the committee to promote safe and healthy communities.

The CHAIRMAN. Dr. England.

Dr. ENGLAND. Senator Jeffords, Senator Dodd, it is really an honor to have an opportunity to present to you today and support access to comprehensive health care for children, in particular, parity for mental and addictive disorders.

I am a child psychiatrist also from Massachusetts, as you can tell from my accent, with 10 years in Massachusetts State Government, responsible for children and family services and for mental health services. Most recently, for the last 9 years, I have been program director for Robert Wood Johnson's Mental Health Services Program for Youth, as well as a program for the Center for Mental Health Services for 22 States, providing services for children with serious mental illness.

I am also the president of the Washington Business Group on Health, whose board strongly supports universal access for all Americans and particularly understands that we need to have an incremental support, and we strongly support universal access to health care for all of our children, for every child in America, and that in particular it should include parity for mental and addictive disorders.

I would like to speak about three things—the problem area; second, the whole area of treatment is effective; and third, some of the successes we have had in the treatment of children with mental illness.

There are 11 million children in this country with mental illness problems; 20 percent of children in this country have some kind of mental illness, and only one-third of them have been treated, as Senator Paul Wellstone clearly articulated earlier. Only one-third are being treated, and that treatment is often inadequate for the needs of these children.

The NIMH has done studies showing that the prevalence of mental and addictive diseases is higher for those who are poor or for the working poor. In fact we know that increasingly, the uninsured are the working poor. So, with the problems of children with serious mental illness within that group, it is desperately important that we provide insurance for children, not just Medicaid for children of parents who are working, but for children of parents who are working and do not have health insurance.

It is also important to understand that children are not really small adults. Oftentimes, we think of them as the same as small adults. They really are different, and they need family and community support to be able to provide the kind of environment for them to grow as they need to.

We strongly support an integrated system of care approach to these children where you integrate financing and delivery into what we call an organized system of care, involving the schools. We strongly support school-based clinics; there are now about 1,000 of them throughout the country, and we have worked very strongly to be sure that there are mental health services in those programs. They often get started thinking they do not need mental health,

and about 40 percent of the kids who came into those programs needed mental health or addiction services.

Probably the most important news I have to tell you is that treatment for children with mental illness is very effective. We have come a long way in the last few years, and our children are better; those who are diagnosed and treated are much better than they have been in the past. Employers recognize this as well and have begun to recognize that benefit limits create barriers to care. So the old idea of having a limited memo on addictive benefit packages has proved to be unsuccessful—in fact, driving up some of the costs that Senator Dodd spoke to—because it has driven inpatient care, rather than having appropriate ambulatory, community-based, home-based care.

Employers understand that we need to move to performance-based standards, outcomes-based patient and family-centered care, for people with mental and addictive disorders. Digital Equipment Company in Maine and Massachusetts has been a leader in this area, eliminating any benefit limits in the areas of mental and addictive diseases, understanding the need for specialists and also understanding the need to measure the linkages to systems of care, because if HMOs do not do business with the schools and understand the importance for these youngsters, they do not get the kinds of services they need.

Also, Digital has requested of its HMOs to begin to develop community-based resources like home-based services, respite care. These families that assume responsibility for these children take a great deal onto their shoulders, and we want to be able to allow them to keep those children at home.

In fact, increasingly, our goal is for early detection and treatment. Ron Kessler, a professor at Harvard University has shown that children with emotional disturbances have better than a 50 percent chance of going on to addiction. We have sort of a window of opportunity of 4 to 6 years after kids have been identified with serious mental illness before they also have a co-occurring illness of addiction.

But there are successes across this country, and they are supported by the family movement. We have a very strong consumer movement—and I wish Senator Mikulski was here—we have a strong, passionate movement across this country to support children with serious mental illness. In Vermont, we have an excellent program called New Directions. It has been there for 8 years and was initially founded by the Robert Wood Johnson Foundation and went on to get Center for Mental Health Services funding. It is statewide reform to integrate all the services these youngsters need. It is pooled funding so that the child's individual treatment plan drives the financing—because so often in the past, we have just put the child where there might be some financing, like inpatient care, as opposed to providing the children and family what they really need.

Private employers use this system, and their per capita costs have gone down in the treatment for these children.

We have another very successful program, Wraparound Milwaukee. A very important part of the Medicaid financing program is that it is flexible, and it allows a continuum of care for children

with serious mental illness. It is a care management approach where we are actually able to blend funds, where we take money from all the categorical agencies that these children use—schools, child welfare agencies—and we are able to provide them with the care they need.

So the result and the good news to you all is that the kids are better when they are diagnosed and treated. They go to school, their grades improve; detention stays and arrests go down, out-of-home placement and hospitalization is decreased. Kids are served in their communities, with their families, and there are more dollars available for other children to receive the care.

The Washington Business Group on Health and the business community of large employers support your move to cover children with comprehensive health care and to particularly insure parity for mental and addictive disorders.

Thank you for this opportunity.

[The prepared statement of Dr. England follows:]

PREPARED STATEMENT OF MARY JANE ENGLAND, M.D.

Mr. Chairman and members of the committee, thank you for the opportunity to address you on the mental health needs of children and their families. My name is Mary Jane England, MD. I am a child psychiatrist and immediate past president of the American Psychiatric Association. Throughout my career, I have had an abiding concern for children with emotional and behavioral disturbances and their families. I entered public service in Massachusetts as Associate Commissioner of the Massachusetts Department of Mental Health Services, then served as the first Commissioner of the Massachusetts Department of Social Services. For the past nine years, I have directed the Mental Health Services Program for Youth (MHSPY) supported by a landmark $20 million grant from the Robert Wood Johnson Foundation. Through this program, we developed eight model delivery systems to serve children with serious mental illness and their families, and have expanded this initiative to 29 sites. Since 1993, I have also been responsible for the National Resource Network for Children and Family Mental Health Services at the Washington Business Group on Health, a program that provides training and technical assistance to demonstration sites developing community-based integrated delivery systems for children.

I currently serve as President of the Washington Business Group on Health, whose Board of Directors has identified children's health coverage as a top priority. The Washington Business Group on Health represents employers in promoting performance-driven health care systems and competitive markets that improve the health and productivity of companies and communities. WBGH is the only national non-profit organization devoted exclusively to the analysis of health policy and related workplace issues from the perspective of large employers. Typically Fortune 500 and large public employers, WBGH members include the Nation's most innovative health care purchasers, who provide health care for more than 39 million U.S. workers, retirees and their families.

WBGH's Board is deeply committed to comprehensive coverage for every American, but recognizes that it is best to pursue this goal through incremental steps. WBGH member companies depend on a healthy, well-trained workforce to be competitive. As the future workforce, children represent a critical and vulnerable group that must have access to quality health care services.

Continued reform of our health care system is necessary to adequately meet the health care needs of our Nation's children. Narrowly focusing on the financing of health insurance will not necessarily ensure that our Nation's children have access to care that is appropriate and of high quality. The U.S. health system is undergoing fundamental change, and both public and private sector purchasers of health care are helping to transform fragmented and inefficient health services into more organized and accountable delivery systems. While there is no "one size fits all" approach for serving the needs of children with emotional or behavioral disorders, there are some solid models we can look to in the public and private sectors as we consider alternatives for improving the health care for our Nation's children.

Children's Mental Health Needs

An estimated 20 percent, or 11 million American children and adolescents have serious and diagnosable emotional or behavioral health disorders, which range from

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attention deficit disorder (ADD) and depression to bipolar disorder and schizophrenia. Of these 11 million, roughly 2.5 million have a disorder that is considered severe and requires more intensive service intervention. Unfortunately, less than one-third of children and adolescents with a diagnosable disorder receive appropriate treatment. In children, precursors to emotional and behavioral disorders are often present and provide an opportunity for early recognition and treatment that can minimize and frequently prevent more serious problems in adult years.

The prevalence of emotional and behavioral disorders varies by income, with poor (0–99 percent of poverty) and low income (100–199 percent of poverty) children and adolescents experiencing the highest rates. Disorders are also more prevalent among children and adolescents who are covered under Medicaid or who are uninsured (and most likely to be poor or near-poor), according to a study sponsored by the National Institute of Mental Health. Researchers found that 31 percent of Medicaid-covered children in their sample met the criteria for having a serious emotional disorder and 18 percent of children without health coverage met the criteria. In contrast, only 12 percent of children with private health insurance met the criteria for a serious emotional disorder.

These data show that many of our children most in need of mental health services are more likely to be covered by Medicaid or to be uninsured. The data may also imply that the emotional and behavioral health needs of children may drive Medicaid enrollment rates, as the prevalence of emotional disorders is higher for Medicaid than the uninsured. Such information could prove useful in outreach efforts designed to increase enrollment of Medicaid-eligible children.

A large percentage of private-sector mental health services go to treating dependent children of working adults. Employers that have removed benefit limitations and restructured their mental health benefits have discovered that, like children covered by the public-sector, their employee and dependent populations include children who require intense or chronic behavioral health services. When dependent children experience emotional or behavioral health problems, the parents work performance and attendance is directly affected. Sometimes parents of children with severe emotional or behavioral health conditions must drop out of the workforce to care for these children, or are unable to maintain employment as a result of the tremendous family disruption caused by untreated problems.

Untreated emotional and behavioral health problems can have serious consequences for children, families, communities, and our society as a whole. For example, the research of Ron Kessler from Harvard University shows that children with mental health problems like anxiety, depression, and attention deficit disorder are at extreme risk for developing substance abuse disorders as adults. The good news is that we now have effective treatments and can produce measurable outcomes in caring for children with behavioral and addictive disorders. Treatment programs are being developed to manage co-occurring mental health and addictive disorders. Early and appropriate treatment improves school attendance and grades, keeps children and adolescents out of the juvenile justice system, and reduces hospitalization, which helps keep families together. Moreover, early treatment can help a child grow and develop into a healthy and productive adult. For the private-sector, the implications are clear. Healthy children and families produce healthy and productive workers and companies.

Finally, it is important to note that children are not miniature versions of adults with respect to their physical and mental health needs. The most important difference between children and adults when it comes to the provision of health care services, is the role of the family. With children, the family plays a critical role in a child's environment and is absolutely essential in successfully preventing, detecting, and treating children and adolescents with emotional and behavioral disorders.

To Insure or to Ensure?

Insurance coverage alone will not ensure that children's health needs are met, especially their mental health needs. First, not all insurance policies or plans cover mental health services. Approximately 2–3 percent of health insurance policies do not cover mental health benefits. In addition, many policies limit certain types of services, such as inpatient care or treatment for substance abuse. More important, having mental health insurance does not ensure that appropriate services will be available or provided. Children's emotional and behavioral health problems often go unrecognized in the primary care setting. In addition, too many health plans today are uninformed about the special needs of children, or are unable to establish contractual relationships with appropriate child mental health professionals, such as child psychiatrists. Finally, in many communities across the country, there simply are no child psychiatrists, or there are not enough child mental health professionals to meet the demands of the community.

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It is very important to look at when, where, and how children and their families access mental health services to understand why health insurance won't solve all access problems. The NIMH research shows that whether a child has private or public health insurance has little bearing on whether a child is actually able to receive services, and where those services are obtained. This is not the case for general health services, for which insurance is a key factor in whether an individual is able to access services, according to research by the Kaiser Family Foundation.

A large proportion of children's mental health services are provided in the community. Indeed, the public sector is the major funder of mental health services for children and' adolescents. State and local governments finance 25 percent of all mental health expenses in addition to their share of Medicaid. For children, the school system is the most important single source for identifying and accessing mental health services.

The Need for Delivery System Reform

Private Sector—The delivery of mental health services in the U.S. is in need of fundamental reform. A private-sector trend in the 1980s to reign-in out-of-control mental heath expenditures through plan design limits created barriers to care for many workers and their families. Instead of encouraging prevention and early intervention, plan design limits allowed many people with mental illness to go untreated. Lack of treatment often leads to more disabling and costly conditions and results in millions of dollars in indirect costs such as lost work time, accidents, inappropriate use of medical services, and decreased worker productivity.

In addition, mental health services funded by private-sector dollars tend to emphasize acute or episodic care, and often lack the system necessary to support and maintain the functioning of individuals with chronic and/or severe psychiatric problems. As a result, many families with seriously impaired children rely heavily on publicly-financed services once they have exhausted their benefits or encountered a roadblock in their treatment.

Public Sector—In the public sector, a substantial amount of money goes to services for children with serious behavioral health disorders, and their families. In most States, there are five categorical agencies—child welfare, mental health, public health, education, and juvenile justice—that share responsibility for children with serious mental health disorders. However, these agencies generally do not coordinate their efforts, resulting in inefficient spending and fragmented services that do not produce good results for children. Fragmentation of delivery often results in heavy and long-term use of inpatient hospitalization for children, and much pain and frustration for the families of these children.

The Organized Systems of Care Ideal

Fortunately, large employers are increasingly abandoning the practice of cost-control through benefit design limitations. Instead, innovative large employers are taking the lead in driving important changes in our Nation's health care system by holding the-line on cost and demanding value and quality in the health care they purchase for their employees. More and more employers are adopting sophisticated purchasing techniques to reward outcomes-based, patient-centered delivery systems. Acting on behalf of their employees, large employer-purchasers are demanding that the health plans with which they contract achieve measurable performance standards. The proliferation of report cards, accreditation standards, and new consumer satisfaction measurement tools are indicative of this trend.

These quality and performance initiatives are increasingly being applied to mental health and substance abuse programs. A 1997 survey by William M. Mercer, a benefits consulting firm, found that a large majority of employers are requiring performance guarantees from companies retained to provide behavioral and mental health services to employees and dependents. These employers measure performance in areas such as: access to mental health care services, availability of grievance resolution measures, timely and accurate processing of claims, and provider credentialing.

Digital Equipment Corporation, for example, is a leader in health care quality improvement efforts, particularly in the area of behavioral health. Without using benefit limitations, Digital has been able to control costs and improve the quality of services provided by HMOs through its comprehensive performance standards that measure HMO performance against Digital's expectations for managed care plans. Introduced in 1991, Digital's behavioral health standards were developed to address common problems in the delivery of mental health services, including: barriers to initial access, lack of specialty staff, absence of case management, rigid adherence to benefit design, and lack of documentation of value received by patients.

Digital recognizes the complex nature of behavioral health problems and carefully evaluates a health plan's ability to link multiple systems—HMO, primary care physician, employee assistance program (EAP), disability case manager, workers com-

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pensation case manager, and community service providers—which is critical in caring for children with behavioral health problems. Moreover, Digital requires HMOs to participate in the development of community resources (e.g., community behavioral health centers, halfway houses, etc.) where gaps exist in the HMOs services for the full continuum of care.

Large employers are deeply committed to improving the quality of heath care for all our Nation's citizens. They understand that the discrete problems in health care—uncontrollable costs, variable and unknowable quality, and unequal access—cannot be fixed unless the delivery system is continually improved. These employers support performance-driven, outcomes-based, patient and family-centered delivery systems, and believe that transforming the way health care is organized and delivered is essential to contain costs and improve quality of care. WBGH articulates this vision through its organized systems of care (OSC) model.

As described by WBGH, the OSC is a health care system that both finances and delivers care and is held clinically and fiscally accountable for the outcomes and health status of the enrolled population and ultimately the community. The OSC is dedicated to mitigating the effects of illness and disability and improving health. Health is regarded as a dynamic state with illness prevention and continual improvements in health status high priories. Behavioral health is recognized as an integral part of individual and community health.

The OSC model is flexible enough to match community resources and needs, but always coordinates the delivery of a full continuum of care, across a variety of treatment settings from technically complex to an individual's home. Care is integrated, patient-centered, and often delivered by a multi-specialty team of clinicians. In addition, there is integration with other public and private systems as appropriate to serve the individual with special health needs.

Today's managed care plans do not meet the criteria of an organized system of care. Nevertheless, some of the best plans are starting to exhibit key characteristics of OSCs, and these plans should be rewarded and encouraged in their efforts. While managed care is less than perfect, it does offer many advantages for consumers. It can keep costs under control, provide a foundation for measuring performance; provide an infrastructure for building useful information systems; be held accountable for its performance; coordinate and integrate care and treatment; and focus on prevention and early intervention.

Models that Work

It is possible for public agencies to collaborate and develop organized systems of care that can meet the needs of children with emotional, mental, and behavioral disturbances and their families. It is also possible for the public and private sectors to work together in building a cohesive delivery system. Multiple financing streams are acceptable, as long as the streams flow to organized care systems at the community-level that are flexible enough to support individualized treatment plans for the small number of children with the most senous mental health problems. In simple terms, the child and family's individual treatment plan should drive the financing—not the other way around. While this sounds complex and unlikely, there are some successful models that can be emulated on a national-scale for all children.

A new set of organizations is emerging around the country to respond to the needs of children with serious mental health problems. These organizations have been inspired by the Child and Adolescent Service System Program (CASSP), of the National Institute of Mental Health, to encourage States to plan across categorical agencies—such as child welfare, mental heath, special education, public health, substance abuse and juvenile justice—to create systems of care that more effectively meet the needs of children with severe emotional and behavioral disorders. CASSP has made important improvements in the delivery- of services to children with emotional and behavioral disorders and provides a model for delivery system reform.

The National Resource Network for Child and Family Mental Health Services at WBGH is a real success story. It provides training and technical assistance to demonstration sites developing community-based integrated delivery systems using a multi-disciplinary approach that involves the public and private sectors. The goals of the program are to: expand the service capacity in communities that have developed an infrastructure for an interagency approach; provide a broad array of services that are community-based, family-centered, and individualized; and ensure full involvement of families in the development of local services and in the care of their children. Congress recently reappropriated $69 million for this important program that builds and integrates delivery systems for children with serious emotional and behavioral disorders.

The New Directions project in Vermont is a good example of how financing and delivery system reforms can improve the care provided to children with serious mental and behavioral health problems, without creating new spending. Under the Men-

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tal Health Service Program for Youth (MHSPY), we have been able to tunnel funding from multiple State agencies into the development of a comprehensive system of community-based care on a state-wide basis. The blended funding stream is tunnelled through an interagency pool which is then used for individualized treatment plans. In a couple of instances, private-sector employers have directed money to this program because they felt it provided a better delivery system for an employee's dependent child. This program has improved quality and continuity of care and has reduced per capita costs from $50,000 to $30,000, largely by returning children from out-of-state placements and caring for them in the new local system of care.

The "Wraparound Milwaukee" project in Wisconsin is another success story. This program was designed around a "care management" model that blends funding streams to obtain the necessary level of funding for the complex needs of children. It was intended to be a type of public managed care entity, but traditional managed care models that are accustomed to serving large mostly healthy populations would not work for a small population of children with the most serious mental and behavioral disturbances. Instead, the individualized approach led to the development of a smaller, special purpose system of care that is connected to a primary care system. The results of this program are: children are maintained in the home and not in residential treatment programs, there is less family disruption; children have improved outcomes and school attendance, delinquent acts have declined; and the program saves money because funds and care are allocated and delivered with more efficiency.

In conclusion, those of us who have worked to improve the health care situation for children applaud the efforts of Congress and this committee to take steps to advance this very important cause. As we continue our efforts to improve the delivery system, our goal is to build systems of care that can serve all children's health needs. It is not enough to just take care of children in the private sector, or those who only have primary care needs, or those with the most serious disorders. We have best practices in the private sector and demonstration projects in the public sector that can provide you with ideas and models for improving the health status of all children. Meeting the health care needs of America's children is the right thing to do. We stand ready to help you as you move forward with your children's health initiatives.

The CHAIRMAN. Thank you both for truly excellent testimony.

One of the matters that concerns all of us is the incredible increase in suicides since 1960—the incidence has tripled for young males and doubled for females. How can we better identify these at-risk children to help them, and what can we do?

Dr. ENGLAND. I feel that the whole movement to school-based clinics and the movement to demystifying and destigmatizing mental health services are very important. School-based clinics are where kids are, and where there is even the use of peer counseling, where kids can come in and have someone they can talk to who may also be feeling depressed and unhappy.

We have had a lot of success in the area of management of depression at the work site. That model is a good model for schools as well, where we move in and train the workplace in early recognition and detection of depression. The same should be true in the schools, where we can move in with child mental health professionals and train the teachers to recognize early the symptoms of depression and anxiety and make that kind of referral to a specialist and hopefully, locate those services in the schools.

We have treatments that are effective today. The unfortunate thing is that people do not recognize the problem and do not make the referral.

The CHAIRMAN. Mr. Copple.

Mr. COPPLE. I would echo much of what Dr. England has said in terms of where we need to be identifying and delivering services. We remain as always concerned about suicide while under the influence, especially as children are getting younger in the onset of first use of drugs and alcohol and its impact related to self-destruc-

tive behavior. We need to do a better job of early identification and delivering those services where we can best access young people, and that is at the school level; I would agree with Dr. England.

Dr. ENGLAND. I would like to support the notion very clearly that we not in way consider not covering children at least up to the age of 18, because adolescence is a very troubling time, with the risk behaviors, and they are not the most beloved of our population, so they tend not to get the kinds of services they need. So I would encourage you to ensure that it be at least to age 18 that we provide this comprehensive care.

The CHAIRMAN. I have to start another proceeding on early education, so I will have to leave in 5 minutes, but Senator Dodd, if you want to continue thereafter, that is fine with me.

Senator DODD. You are very gracious, Mr. Chairman, and I should have said this at the outset, but I want to thank you, Mr. Chairman, for holding this hearing today. You have been a champion on these issues for a long time, and I know it takes a lot of time. And I want to particularly thank both of you. You have been here all morning—I have seen you sitting out there as we have gone through the earlier witnesses—and we really appreciate you staying here and offering the kind of testimony you have.

Mr. Chairman, this is very helpful that we are able to air some of these issues and discuss the broad questions that need to be addressed as we look at children's health, so it has been very, very valuable.

Dr. England, Senator Hatch and Senator Kennedy have this bill in; have you had a chance to look at it?

Dr. ENGLAND. Yes.

Senator DODD. What do you think? Do you support it or endorse it? I am cosponsor, and the chairman is a cosponsor as well. What do you think of it?

Dr. ENGLAND. We strongly support the principles of moving forward to get comprehensive coverage for children.

Senator DODD. How about that bill?

Dr. ENGLAND. Well, we have some areas that we would like to discuss with you and with the members of the committee, but we have already told the Senator that we are very supportive of the basic premise.

Senator DODD. All right. I have had this chart up here all morning, and I saw you look at it.

Dr. ENGLAND. Yes.

Senator DODD. Your business is to sell insurance to employers——

Dr. ENGLAND. No.

Senator DODD. I thought part of what you do is you kind of promote health care, or they come to you and consult with you about what are the best plans for their businesses.

Dr. ENGLAND. We do not represent the insurers; we represent the large employers.

Senator DODD. Excuse me—my point being that you understand health care plans.

Dr. ENGLAND. Yes, I do.

Senator DODD. And employers come to you and they want to know what are good plans.

Dr. ENGLAND. Yes.

Senator DODD. What is happening here, and how can we close this gap? I think we know what is happening, but how can we close this gap where we are seeing the trend lines, as I mentioned earlier, of more and more families ending up on the rolls of uninsured? And by the way, I understand that for a small business, when these costs go up, it is the choice of staying in business or not. It is not a question of not wanting to cover their employees. They care about them, they value them, but they are also looking at a bottom line that says, If I do that, I am really going to have to close the door, and there is no job here.

Dr. ENGLAND. It is not competitive.

Senator DODD. So I understand that, but how do we address it?

Dr. ENGLAND. Well, the large employers, as you know from the GAO study, have not been dropping coverage for these children, but the small employers, for the very issues that you have raised, have been dropping, or have raised the premiums to a prohibitive cost for their employees.

It is something we recognized during the Clinton debate as well, that we need to do something to be able to help the small employer or to help individuals be able to access appropriate care. And that is what I do think this bill does, is allow individuals to be able to purchase health care for their children.

Ideally, for those of us who work in the field of child and family services, we would like to have the families covered as well, because a depressed parent is not exactly always the appropriate person to be taking care of the child, so we would like to be able to get them access to care, too. But we do understand the importance of incremental, and we do support this.

Senator DODD. Yes. We hold a lot of hearings around here on a lot of subject matter, but I will guarantee you that in terms of public interest, I think this—education, where the chairman is going from here, and jobs are obviously important—but this more than anything else—someone said earlier—maybe it was one of the two of you, maybe it was someone on the previous panel—that even though parents want to be covered, the relief of knowing that their children are covered——

Dr. ENGLAND. Absolutely.

Senator Dodd [continuing.] You can almost hear the collective sigh of relief. So I cannot think of a better expenditure of this Congress' time, if I had to make a choice of only one issue—there are others that we need to pay attention to—but this would be it.

Dr. ENGLAND. Senator Dodd, there are also some technical areas that we would like to work with you on as well. Let me just give you one example of where a company could offer, instead of a family benefit or an individual benefit, an intermediate benefit for a single parent and child. That is much less cost to the mom, usually the mom, and the child, and many companies do offer it, but a lot do not. So that if we could have even just some of those kinds of structural changes made available so that employers could use them, I think it would help.

Senator DODD. It might even be helpful for us if you could share with us what is the menu——

Dr. ENGLAND. It is a wide range, yes.

Senator DODD. Of things out there that we can look at as a way of providing some incentives.

Finally—and I know the chairman has to leave—Mr. Copple, I want to thank you for the work you do as well. We just went through a debate here about certification on Mexico and other countries and whether they are being cooperative enough with us. I read in the paper the other day that they stopped a truck going from the United States to Mexico with millions of dollars hidden in its roof, going down there to buy the corruption of Mexican officials subsidized by U.S. users. So that while I certainly want to get more cooperation from Mexico and Peru and Colombia and Ecuador, I keep on reminding people that if we did not consume, they would not grow and manufacture and produce and launder the money. It is the fact that there is this damned demand in this country that goes up all the time that creates the situation in these other nations. I do not excuse them, but I get angry when we seem to put all of our energy on that side of this equation and not enough on a good look in the mirror and at what is going on in our own country that is creating this situation.

So I am tremendously supportive of what you have suggested in your remarks.

I am not much of a golfer, but this Tiger Woods thing last week was just wonderful to watch. And the Nike symbols and the tremendous advertising that goes on in these kinds of things—I am just wondering why we cannot ask some of these great advertising giants and firms that are so successful in marketing clothing lines and sneakers and other things to give us their time to help generate the very kind of promotional activities that have been so successful in marketing a pair of sneakers—in fact, we see the violence that sometimes occurs when children try to acquire some of these articles of clothing—if they could help us design and promote an educational campaign aimed at these very kids, I have often wondered if we would not have more success.

Mr. COPPLE. Well, in fact, I think General McCaffrey has suggested in his budget and the President's budget $175 million to be used for a media campaign that would be matched by private contributions from advertising firms. But we have had conversations with General McCaffrey, the director of ONDCP, and we need that kind of media blitz and media concern. But as we saw McDonald's put $85 million in support of their "Arche Deluxe" hamburger, and Microsoft spent $125 million in support of a computer program, they knew they had stores in local communities that were going to sell this product.

We have got to be sure that we have a national infrastructure of community-based prevention and treatment to support the demand created by an advertising demand——

Senator DODD. A very good point.

Mr. Copple [continuing.] Because the demand that is out there is only increasing. And the issues that Dr. England has addressed—we have got to be sure that we have a Federal, State and local response that is comprehensive and inclusive.

Senator DODD. That is a great point, and you are so right——

The CHAIRMAN. Let me interrupt because I have to leave——

Senator DODD. I am going to pass a lot of bills when you walk out of here, you know. [Laughter.]

The CHAIRMAN. Be my guest.

Just a couple of things for the record. Senator DeWine and Senator Hutchinson desire and have permission to submit statements as well as questions to the panels, and I will have additional questions for you both.

[The prepared statements of Senators DeWine and Hutchinson, as well as questions and responses were not submitted at press time. They will be retained in the files of the committee.]

The CHAIRMAN. Senator Dodd, you can remain if you wish——

Senator DODD. I have just one last question.

The CHAIRMAN. Very well, then, if you would like to conclude questions for the panel.

Senator DODD. Thank you, Mr. Chairman, very, very much.

The CHAIRMAN. Thank you both very much.

Dr. ENGLAND. Thank you, Senator.

Mr. COPPLE. Thank you, Senator.

Senator Dodd [presiding.] I just wanted to underscore your point on the treatment issue, and I hope you keep talking about this, because it seems to a lot of people like it is kind of fuzzy. But I can think of nothing more tragic that a child or an adult who is seeking treatment and is told he has got to wait 6 months or a year. Am I right? This happens——

Mr. COPPLE. Senator, if I could relate a very real and somewhat personal story, when I was working in Wichita, KS, I rode with our gang unit for 8 months. We were doing street intervention. One night, we picked up a young man, did a series of interventions, got him into treatment—he was addicted to cocaine—got him back into school, he graduated from school, went on to a junior college, came back about a year later on Thanksgiving vacation and hooked up with a friend who lived in his neighborhood. That night, he used cocaine, and he went into a major relapse. He went to five treatment centers over the next month and could not get access, could not afford it. A month later, a drug dealer put a gun to the back of his head and killed him.

To me, that has been a graphic illustration of what needs to shift in this country, both in terms of parity for addictive disorders, how we insure them and cover them, and getting access and affordable treatment. It is critical that we put the issue of substance abuse treatment higher on the agenda. We must treat substance abuse as a preventable behavior and a treatable disease, and the reality in this country is that we do not treat other diseases in this country—we do not tell someone who has cancer, here, you have only 30 days for chemotherapy. This is a relapsing disorder and disease, and we have got to treat it accordingly.

Senator DODD. It is just that we put far more energies into some of these other efforts which perhaps generate more attention. There still seems to be the notion that you are guilty, you created this situation, and why should I be spending any money to help you get better. That is basically what people think, and as long as we think that way, it is going to be very difficult to get the kind of political support we need for some of these issues.

I often ask, Dr. England, when I speak to audiences in Connecticut, not necessarily on this subject matter—and I come from a large family and so on—is there anyone in this room who has never had a family member or close friend with a mental health problem, including the broad range of substance abuse and so on. I ask them to please raise their hands if they had not, and I have never seen a hand come up—never. Everybody knows somebody, everybody has had a family member or a close friend—we are not strangers to this, and this is the great irony. We all have people we love and care about deeply who have been in these situations, and that ought to be the base, the political base, if you will, of trying to get some attention and focus on how we can really deal with this issue.

If you really want to stop Mexico and Peru and Colombia and these drug kingpins and others, the best way to do it is to give these people a chance when they realize they have got to get off this stuff, first, and second, to really go after a program to be just as effective in convincing that 8-year-old, or that 9-year-old, or that 10-year-old that there are alternatives in life to that particular route being proposed to them by someone who is trying to back a quick buck and draw them into a dreadful life course.

So I want you to know you have my support in all of this, and I think the support of many of us. Pete Domenici has been terrific on this issue of mental health; we have not had a better champion than he. Paul Wellstone, as you mentioned earlier, has done a lot as well. We are gaining ground here, and we have just got to keep at it now. I think we have a wonderful opportunity this year, and if nothing else comes out of this Congress—and I do not know if much will—this is one thing I am determined to see happen. I really believe that this could make this Congress one of the most successful Congresses. Just to hear that collective sigh of relief from one end of this country to the next, that we have been able to provide at least a safety net of health care for children in this country would make this Congress worth its efforts.

Dr. ENGLAND. We want to work with you.

Mr. COPPLE. Yes.

Senator DODD. Well, thank you again for being here, and thank you for your testimony. And despite my temptation to pass a lot of legislation, I am in the minority here, so this committee will stand adjourned.

[Additional statements and material submitted for the record follows:]

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, LAWRENCE A. STONE, M.D., PRESIDENT

The American Academy of Child and Adolescent Psychiatry (AACAP) thanks you for holding hearings on access to health care for children. Many of the 10 million American children currently without health insurance are children with mental illnesses. These are children who suffer from childhood schizophrenia, depression, attention-deficit/hyperactivity disorder, obsessive compulsive disorder and conduct disorder.

The Academy, representing over 6,000 child and adolescent psychiatrist, urges you to support non-discriminatory coverage for mental illness treatment in any related legislation. The treatment of childhood disorders represents a major public health concern. Chronic mental illnesses respond well to treatment but lifelong access to the health care system is necessary. Successful diagnosis and treatment is a wise investment, given the pain, long-term disadvantages, and financial costs associated with untreated childhood behavioral and emotional disorders.

Health care reform proposals directed toward universal access for children and adolescents can result in a comprehensive change to a new benefit and payment system, or it can reform the existing system of public and private insurers. Whether there is a move to an expanded Medicaid program, a tax-based incentive program for employers or a subsidy program for parents and guardians, we ask that children and adolescents with mental illnesses be assured nondiscriminatory coverage.

RECOMMENDATIONS FOR HEALTH CARE REFORM 1997:

CHILD AND ADOLESCENT PSYCHIATRIC SERVICES

The following three recommendations will support appropriate, quality care under any health care reform system:

Access and Nondiscrimination

1) Children and adolescents have no access to insurance on their own. Provision should be made to include access for all children and adolescents, regardless of their family's status or income level. Access to psychiatric services should be provided on a nondiscriminatory basis integrated with other necessary medical services.

• Child and adolescent psychiatrists are the most highly trained professionals in the service-delivery team.

Trained to assess the biopsychosocial dimensions of most childhood disorders, they should not be excluded because of their unique training nor should it be assumed that other, lesser-trained physicians or health care providers, can treat serious psychiatric illnesses and have the same outcomes at a lower cost.

• Services provided by child and adolescent psychiatrists should not be discriminated against because of misperceptions regarding cost or length of treatment. Excluding physicians who have acquired special training in order to treat children and adolescents is counter productive and not cost effective. Managed care contracts for medical services should not discriminate against physicians or hospitals by forcing unrealistic limits on reimbursement and skewing patients to less skilled persons. Errors in diagnosis and treatment are costly. For children this can mean developmental delays. Appropriate, quality care will be cost effective; artificial limits on who can treat or where and for how long treatment can take place raise questions of liability and quality of care.

• Diagnoses included in the DSM-IV should be reimbursable. Discrimination by insurers against select diagnoses is unacceptable, especially when illnesses are excluded for cost-containment reasons. Numerous insurers across the country have decided that conduct disorders, Tourette's disorder, or attention-deficit/hyperactivity disorder are not reimbursable. There is no reason for denying treatment for these serious illnesses except to control costs or because of a lack of understanding about the seriousness of these illnesses.

Range of Services

2) Services provided should include a wide range of treatment options—including but not limited to preventive interventions, early identification, assessment and diagnosis, case management, outpatient treatment, partial hospitalization, home-based services, detoxification and inpatient treatment. Treatment for children requires that services involve both the child or adolescent and family as well as appropriate collaboration with other significant care givers, teachers, physicians or providers of other needed services.

• Reimbursement for a range of services to treat psychiatric illnesses has increased slowly. Innovations in treatment are inhibited by some reimbursement limitations. The system has tended to favor the most expensive treatment, such as hospitalization and not to include partial hospitalization, or, in the case of residential treatment, shift from including to excluding it with no explanation and no addition of other services.

• The use of inpatient services, like hospitalization and residential care, should not be discriminated against or unfairly capped because of misperceptions about cost or effectiveness. These are necessary treatments for children and adolescents with severe disorders. Community resources are often limited to inpatient services, which has contributed to inappropriate care. A reform proposal must support expansion of community services and adequate reimbursement for providing those services.

• Medicaid is designed to provide mental health services (to eligible children and adolescents). Medicaid's mandatory services for children and adolescents with psychiatric illnesses cover outpatient hospital services, including partial hospitalization, inpatient hospital and physician services, and services under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. In 1989, Medicaid was amended to require the provision of treatment and follow-up services for problems

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identified through EPSDT screening even if the state does not normally cover such services through Medicaid.

Most states have not been able to comply with the expanded Medicaid requirements, primarily for economic reasons that impede the training of screening personnel, the establishment of referral protocols, and the inability to reimburse for professional services at any more than a minimal level; however, the language of the law reflects a reliable model for both prevention and treatment of serious emotional disorders.

Cost containment

3) Incentives should encourage the use of the earliest of interventions, the level of treatment necessary, treatment and management by an appropriately trained physician, and the most appropriate treatment setting possible, all of which would best serve the child's clinical goals in an economically prudent manner.

• Managed care, when used for cost containment, should not be equated with minimum care. Competition for contracts can lead to mental health benefit packages that discriminate solely because of the stigma of the illnesses involved. Children and adolescents with psychiatric illnesses often require complex diagnostic processes. Comorbidity is high in diagnoses such as conduct disorder or attention-deficit/hyperactivity disorder, and adjustments in the treatment plan may be necessary. Inflexible packages obstruct even standard treatment plans for children and adolescents. Diagnoses of comorbidity require trained child and adolescent psychiatrists. To miss a diagnosis and leave it untreated, lengthens the treatment and adds to the cost of the illness.

• The use of managed care to control medical services must be regulated. The managed care industry's practices vary widely in organizational structure and quality. Reform measures will be compromised if regulation and oversight are not included. Improper utilization review can grossly compromise the treatment and significant psychiatric or physical harm may result. Too often, child and adolescent psychiatrists find that reviewers do not have enough knowledge about treating young patients. Even medical directors, unless trained in child and adolescent psychiatry, make treatment plan review recommendations based on adult practice guidelines.

• Case management is essential to mental health care reform. Negotiating with agencies, resources, providers, and specialists is difficult and frustrating, and delays in treatment can result. Case managers must be trained to access a wide range of services and be appropriate in referring to those services.

Child and adolescent psychiatrists are physicians who are trained to treat the psychiatric illnesses of children, adolescents and adults. Their skills incorporate the broadest range of treatment skills available for treating the biopsychosocial facets of mental illnesses. Access to care by a child and adolescent psychiatrist should not be excluded or limited because of discrimination, stigma or misperceptions about cost and effectiveness.

Conclusion

The American Academy of Child and Adolescent Psychiatry thanks you for your consideration of children and adolescents with mental illnesses. Child and adolescent psychiatrists treat youngsters with serious mental illnesses and understand the problems of inadequate health insurance. When treatment is delayed, families suffer, financial burdens expand, and social services are overwhelmed. AACAP urges you to support health insurance coverage for all children and adolescents with mental and physical illnesses. Children must have access to the appropriate treatment and services needed to develop into productive and independent adults.

PREPARED STATEMENT OF THE AMERICAN DENTAL HYGIENISTS' ASSOCIATION, STANLEY B. PECK, EXECUTIVE DIRECTOR

The American Dental Hygienists' Association (ADHA) is the largest national organization representing the professional interests of the approximately 100,000 dental hygienists across the country. Dental hygienists are preventive oral health professionals, licensed in dental hygiene, who provide educational, clinical and therapeutic services that support total health through the promotion of optimal oral health.

ADHA is pleased to, share its views with regard to children's access to health coverage. In particular, we urge that any children's health legislation include measures to improve access to oral health care services. This is important because the Institute of Medicine estimates that 50 percent of Americans do not receive regular dental care. This figure is likely far higher for the population that children's health initiatives seek to cover.

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ANY CHILDREN'S HEALTH INITIATIVE SHOULD INCLUDE MEASURES TO PREVENT ORAL DISEASE

Because ADHA feels strongly that all Americans should have access to affordable quality health care services, including oral health care services, ADHA is pleased with the significant level of interest and commitment in the 105th Congress to increase health insurance coverage among our Nation's 10 million uninsured children. We are committed to participating in this process to ensure improved access to cost-effective quality health care coverage, including, at a minimum, preventive oral health services. Oral health is a part of total health; therefore oral health must be included in any children's health care initiative.

THE NATION'S ORAL HEALTH

Oral health is fundamental to total health. As former Surgeon General C. Everett Koop noted, "if you don't have oral health, you're not healthy." Despite recent advances in preventing oral disease and maintaining oral health, *oral diseases still afflict 95 percent of all Americans.* Oral Health America/America's Fund for Dental Health reports that 9 million school days are lost annually because of oral health problems.

COST-SAVINGS ASSOCIATED WITH PREVENTIVE ORAL HEALTH CARE

In contrast to most medical conditions, *the three most common oral diseases—dental caries (tooth decay), gingivitis and periodontitis (gum and bone disease)—are proven to be preventable* with the provision of regular oral health care. This proven ability translates into huge cost savings. Each $1 spent on preventive oral health care yields $8–$50 in savings. Because of this, increased access to preventive oral health services will likely result in decreased oral health care costs per capita and, more importantly, improvements in children's oral and total health.

Preventable oral diseases currently afflict the majority of our Nation's children. Dental caries (tooth decay), gingivitis and periodontitis (gum and bone disorders) are the most common oral diseases. In fact, the Public Health Service reports that fifty percent of all children in the United States experience dental caries in their permanent teeth and two thirds experience gingivitis. If untreated, gum disease causes bone deterioration and eventual loss of teeth, pain, bleeding, loss of function, diminished appearance, and possible systemic infections. Each of these oral health disorders—dental caries gingivitis and periodontitis—can be prevented through regular preventive care.

All American children should have access to oral health coverage as one way to support total health. Ideally, every child should have access to diagnostic, preventive, restorative and periodontal care, as well as emergency care to treat pain. At a minimum, however, preventive services should be available as an investment for long-term savings.

Additionally, any effort to revamp the present Medicaid and Medicare health care delivery systems or to advance incremental health care reform legislation should embody as one of its goals increased access to preventive oral health care services.

A 1996 U.S. Department of Health and Human Services (HHS) report on *Children's Dental Services Under Medicaid* indicated that, despite the provision for oral health benefits under Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, *only 1 in 5 (4.2 million out of 21.2 million) eligible Medicaid children actually received preventive oral health services in 1993.*[1] *This represents a slight decrease from 1992 data. The 1996 HHS report attributes the low utilization rate for preventive oral health services to "the shortage of dentists who are willing to accept Medicaid patients."*[2] *Clearly, this trendline must be reversed. Dental hygienists can, and should, play a larger role in the delivery of oral health services to underserved populations, including Medicaid-eligible children. The Nation's health care system must be reoriented to focus on preventive and primary care services including those provided by dental hygienists.*

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[1] *Children's Dental Services Under Medicaid: Access and Utilization,* U.S. Department of Health and Human Services, Office of the Inspector General, April 1996, (OEI-09-93-00240) at page 6.

[2] *Id.* at page 7.

CHILDHOOD IMMUNIZATIONS SHOULD INCLUDE MEASURES TO *PREVENT DENTAL DISEASE*

ADHA urges that any children's health initiative improve access to the known benefits of preventive oral health care services. The increased access to oral health care for children that ADHA advocates can be achieved through the inclusion of dental sealants and fluoride in any definition of childhood immunizations. While research to develop a vaccine against dental caries (tooth decay) continues, we can today effectively guard against tooth decay—which is an infectious, transmissible disease—with the combined use of dental sealants and fluoride.[3] These services protect children against tooth decay just as vaccines immunize against certain medical diseases.

Dental Seealants

Pit and fissure adhesive sealant protection for the eight permanent molars (6-year and 12-year molars) is needed when the crevices in these teeth are deep. Sealants are thin plastic coatings that seal crevices in the teeth and act as a physical barrier to prevent oral bacteria from collecting and creating the acid environment essential to the initiation of oral disease. No discomfort is involved in sealant applications, which cost approximately $20–35 in private settings, and even less in public health settings. When properly applied, sealants are virtually 100 percent effective in preventing tooth decay in the pits and fissures of molars.

The National Institutes of Health (NIH) and former Surgeon General C. Everett Koop endorse the use of sealants. One of the objectives in Health People 2000, the national health promotion and prevention agenda, is to increase to at least 50 percent the proportion of children who have received protective sealants.

Fluoride

Appropriate use of fluoride can reduce smooth surface tooth decay in children. Optimal availability of fluoride from multiple sources, such as community water fluoridation, self-applied fluorides, and professionally applied fluorides, are effective in preventing dental decay.

Effectiveness

Together, dental sealants and fluoride are virtually 100 percent effective in protecting children against tooth decay and its physical, financial, academic, emotional, and social consequences. Accordingly, ADHA urges that any definition of immunization include dental sealants and fluoride.

CONCLUSION

Preventable oral diseases still afflict most of our Nation's children, compromising their health and unnecessarily adding to health care costs. ADHA urges this Subcommittee—and all Members of Congress—to ensure that any children's health initiative promote access to quality, cost-effective preventive oral health care services. Ideally, all American children should have access to diagnostic, preventive, restorative and periodontal care, as well as emergency care to treat pain. But, at a very minimum, children need access to basic preventive oral health care, including education in self care, routine teeth cleaning, provision of fluorides and sealants, periodontal maintenance and routine x-rays.

ADHA stands ready to work with the Nation's policymakers to improve children's access to preventive oral health services, which will achieve savings of billions of health care dollars and improve children's oral health, a fundamental part of total health.

ADHA appreciates this opportunity to submit its views. For further information, please contact our Washington Counsel Karen S. Sealander of McDermott, Will & Emery (202-778-8024).

PREPARED STATEMENT OF THE COUNCIL OF WOMEN'S AND INFANTS' SPECIALTY HOSPITALS, SUSAN ERICKSON, PRESIDENT

The Council of Women's and Infants' Specialty Hospitals (CWISH) is a group of eight of the largest freestanding subspecialty perinatal hospitals dedicated to the de-

[3] Research shows that the presence of bacteria known as mutans streptococci leads to dental caries in children. This decay causing bacteria is typically transferred from primary caregivers to young children between 22–26 months of age.

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livery of high risk obstetrical and neonatal care to mothers and their infants.[1] CWISH is pleased to present its views with regard to children's access to health coverage.

Because **access to risk-appropriate prenatal care is known to improve the outcome of pregnancy,** inclusion of health insurance coverage for pregnant women in any children's health initiative will contribute to the goal of improved health for the nation's children. Accordingly, CWISH urges that **health insurance coverage for pregnant women be included in any children's health initiative.**

Further, children's health legislation must specifically assure access to quality, cost-effective high risk obstetrical and neonatal care for both pregnant women and infants. Access to high risk obstetrical and neonatal services is critical because studies show that **premature and low-birthweight infants born in large Level III subspecialty hospitals—such as CWISH hospitals**—*fare better* than high risk deliveries in other settings *without increased cost.*[2] Moreover, a healthy pregnancy and delivery bolsters the chances for a healthy childhood and can avert expensive acute and/or long-term care.

CWISH SUPPORTS EXPANDED MEDICAID OUTREACH

CWISH is pleased with the significant level of interest and commitment in this Congress to increase health insurance coverage among our nation's ten million uninsured children, including the three million children eligible for, but not receiving, Medicaid benefits. CWISH is well aware of Medicaid's importance to the health of pregnant women and infants. Indeed, CWISH is a significant participant in the Federal Medicaid program, with Medicaid payments constituting up to 65 percent of the care provided by our hospitals.

As Congress undertakes to reform the Medicaid program, we urge this Subcommittee—and all Members of Congress—to facilitate outreach and other programs to ensure health care coverage of all Medicaid eligible pregnant women and infants and to ensure that CWISH and other subspecialty perinatal hospitals will be able to provide quality cost-effective high risk obstetrical and neonatal services to pregnant women and infants in their communities, regardless of economic need.

IMPORTANCE OF RISK-APPROPRIATE CARE FOR PREGNANT MOTHERS AND INFANTS

Lack of health insurance often results in lack of timely care, which too often results in costly acute and/or long-term care. U.S. Census Bureau data reveals that one of three children lacked health insurance for one or more months during 1995–96.[3] Many of these uninsured children are members of families where one or both parents are working, but simply cannot afford insurance. Clearly, we must do better.

Appropriate prenatal care for expectant mothers is a major determinant of good pregnancy outcome. In fact, prenatal care, especially among poor, minority and other high-risk women, reduces the risk of low-birthweight threefold and results in lower infant mortality rates and healthier infants. Numerous studies have also shown that women who receive no prenatal care are far more likely to have babies with health problems that could have been prevented or reduced had they received the appropriate perinatal care.[4] According to the American Hospital Association, leading the list of barriers to this important care is inadequate or total lack of health insurance.

Identification of high risk pregnancies and subsequent referral and appropriate treatment by specialists is critical. As cited earlier, the recent study reported in the *Journal of the American Medical Association* confirms that high risk deliveries in large level III neonatal intensive care units (NICUs)—such as those in CWISH hospitals—fare better than high risk deliveries in other settings *without* increased cost. Because the major decline in infant mortality over the past 25 years is largely attributable to better access to the subspecialty services provided at hospitals such as ours, access to these high risk obstetrical and neonatal services must be included

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[1] Perinatal services include maternal and infant care beginning before conception and continuing through the first year of an infant's life.

[2] *The Effects of Patient Volume and Level of Care at the Hospital of Birth on Neonatal Mortality*, Journal of the American Medical Association, Volume 276, No. 13, October 2, 1996, p. 1054.

[3] *One Out of Three: Kids Without Health Insurance 1995–96*, Families USA Foundation, Washington, DC 1997, p. 1.

[4] *Infants At Risk: Solutions Within Our Reach*, Greater New York March of Dimes/United Hospital Fund of New York, 1991, p. 28.

in any children's health initiative. Indeed, the Finance Committee expressly recognized the importance of access to specialty perinatal care in its fiscal year 1997 reconciliation recommendations (attached in pertinent part).

In conclusion, CWISH strongly advocates access for *all* pregnant women and infants to cost-effective quality risk-appropriate health care. Such care should specifically include high risk obstetrical and neonatal services provided in Level III regional specialty hospitals.

CWISH appreciates this opportunity to submit its views. For further information, please contact our Washington Counsel Karen S. Sealander of McDermott, Will & Emery (202-778-8024).

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BUDGET RECONCILIATION RECOMMENDATIONS OF THE COMMITTEE ON FINANCE

AS SUBMITTED TO THE COMMITTEE ON THE BUDGET PURSUANT TO H. CON. RES. 178

COMMITTEE ON FINANCE
UNITED STATES SENATE

WILLIAM V. ROTH, JR., *Chairman*

JULY 1996

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October 1, 1996.

E. Pre-existing conditions exclusions

Present Law

No provision.

Explanation of Provision

A State is prohibited from denying or excluding coverage on the basis of a preexisting condition. If a State contracts with a capitated organization or other entity and allowed the organization to impose preexisting condition exclusions, the State must provide alternate coverage for any covered services denied as a result.

F. Access

Present Law

State plans must meet the general requirements of comparability (the services available to any categorically needy beneficiary in a State must generally be equal in amount, duration, and scope to those available to any other categorically needy beneficiary in the State) and Statewideness (generally, the amount, duration, and scope of coverage must be the same Statewide).

Explanation of Provision

The State plan must include a description of the State's goals related to access of care for children with special health care needs (as defined by the State). The State plan must assure that beneficiaries have access to nursing facilities and primary care services (within 50 and 30 miles of their residence, respectively, or within a "reasonable" distance in rural areas). States are encouraged to assure pregnant women and children access to appropriate levels of basic, specialty and subspecialty care.

The Committee has included a provision requiring that the State Medicaid plan include a description of the goals and objectives related to standards of care and access to services for children with special health care needs in that State. Children with special health care needs, those with serious chronic conditions or disabilities such as cerebral palsy, cystic fibrosis, cancer, or heart conditions represent approximately 2 percent of all children, but need special attention to make sure their needs are met. While managed care can offer all children and their families better access to care and better coordination of services, managed care plans often have not developed the expertise to treat children with special health care needs. Accordingly, the Committee intends that States outline in their plans how they will provide care to children with special health care needs.

Studies show that the high risk obstetrical and neonatal services provided at Level III regional specialty hospitals have contributed to the decline in U.S. infant mortality over the last 25 years. The Committee encourages the States to put in place protections so that pregnant women and babies receive the basic, specialty, and sub-

specialty care they need in the facility appropriate to their level of risk, including Level III regional specialty care, in keeping with *The Guidelines for Perinatal Care*, American Academy of Pediatrics/American College of Obstetricians and Gynecologists.

5. Delivery Systems

Present Law

Currently, the majority of Medicaid services are provided on a fee-for-service basis.

Under current law State plans must meet three general requirements: comparability (the services available to any categorically needy beneficiary in a State must generally be equal in amount, duration, and scope to those available to any other categorically needy beneficiary in the State); Statewideness (generally, the amount, duration, and scope of coverage must be the same Statewide); and freedom of choice (beneficiaries must be free to obtain services from any institution, agency, pharmacy, person, or organization that undertakes to provide the services and is qualified to perform the services).

States wishing to use Medicaid funds to target otherwise ineligible populations, or to use innovative methods for delivering or paying for Medicaid services may apply to the Secretary for waivers of Medicaid requirements. States wishing to require Medicaid beneficiaries to enroll in managed care plans must obtain one of two types of waivers from the HCFA. Section 1115(a) of the Social Security Act offers States the greatest flexibility, allowing HCFA to waive a broad range of Medicaid requirements. These waivers allow States to expand coverage to those not traditionally eligible, to impose premiums and copayments on those new eligibles, and to modify the Medicaid benefit package. A second kind of waiver, known as a "Freedom-of-Choice" waiver, is permitted by section 1915(b) of the Social Security Act. Section 1915(b) waivers allow States to waive specific requirements for a specific population or geographical area. States do not need waivers to contract with managed care companies; without a waiver, however, States must operate a voluntary system, allowing beneficiaries to choose between an HMO and traditional fee-for-service care.

States are permitted, under the 1915(c) and 1915(d) waiver authority of current law, to offer home and community-based care services to persons who would otherwise require nursing home or institutional care that would be covered by Medicaid.

Explanation of Provision

The State is required to include in its plan a description of the delivery method, such as use of vouchers, fee-for-service, or managed care arrangements. To the extent that medical assistance is furnished on a fee-for-service basis, the plan must describe how the State determines the qualifications of providers eligible to provide such assistance and the method used to determine reimbursement rates for such assistance. The State plan must also describe the extent to which eligible individuals have freedom of choice of providers. States have the option of submitting the State plans that they used under Title XIX (including a plan provided under 1115 waiv-

[Whereupon, at 1:05 p.m., the committee was adjourned.]

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